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HEALTH SAVINGS ACCOUNTS AND THE NEW MEDICARE LAW: THE FACE OF HEALTH CARE'S FUTURE?

HEARING BEFORE THE SPECIAL COMMITTEE ON AGING UNITED STATES SENATE ONE HUNDRED EIGHTH CONGRESS SECOND SESSION

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HEALTH SAVINGS ACCOUNTS AND THE NEW MEDICARE LAW: THE FACE OF HEALTH CARE'S FUTURE?

WEDNESDAY, MAY 19, 2004

U.S. SENATE,
SPECIAL COMMITTEE ON AGING,
Washington, DC.

The committee met, pursuant to notice, at 2:34 p.m., in room SD-628, Dirksen Senate Office Building, Hon. Larry E. Craig (chairman of the committee) presiding.

Present: Senators Craig, Breaux and Dole.

OPENING STATEMENT OF SENATOR LARRY E. CRAIG, CHAIRMAN

The CHAIRMAN. Good afternoon, everyone. The Special Committee on Aging of the U.S. Senate is convened.

Rarely do I convene one of these hearings with such pleasure. I say that because last fall, as part of the comprehensive new Medicare legislation, Congress enacted into law what I believe to be one of the most innovative reforms to American health care in at least a generation. I am speaking, of course, of health savings accounts. Consumer choice in health care is a cause I have been working on nearly all of my years in the U.S. Congress, and it is deeply gratifying to see it come to fruition in such a dramatic way.

To a greater degree than ever before, the new health savings accounts will permit individuals to build significant tax-free health care savings for use in meeting their family's health care needs, including long-term care. Together with high deductible insurance for very high expenses, the new HSAs help put control of health care where it belongs, in the hands of the individual citizen. As we will hear this afternoon, the marketplace is greeting the new health savings accounts with substantial enthusiasm. Sales of individual and small group health savings accounts has been quite brisk, with some companies reporting sales of more than 1,000 health savings accounts in the first week of offering alone, and that is not even counting roll-out of health savings accounts in the ever bigger large group markets, which is expected to get under way this summer. Meanwhile, nearly three-quarters of the employers now say they are likely to offer HSAs for their employees by 2006.

In the midst of all of this, the Department of the Treasury, led by Secretary John Snow, has been moving aggressively to smooth the way toward full health savings account implementation as soon as possible. The Secretary, who we are honored to have with us

today, deserves great credit for wielding his regulatory authority with such speed and effectiveness. Health savings accounts offer a meaningful opportunity to give greater control of health care to consumers themselves and to begin to move away from the increasingly bureaucratic nature of health care today.

Putting people in charge of their own money and their own health care promises to realign incentives to better promote both cost savings and quality. The arrival of health savings accounts also offers needed relief to struggling small employers. Many such employers today face the agonizing choice of paying for traditional insurance they can no longer afford, and dropping health care coverage altogether. HSAs offer a promising lifeline to these companies and their workers.

Finally, HSAs, in my opinion, hold special advantages for older workers and retirees, many of whom face growing health care coverage needs as they approach Medicare age. For example, the HSA law especially permits older workers above 55 to make supplemental catch-up contributions into their HSAs as they approach retirement. Health savings accounts have real promise as a tool to transform the way America relates to health care. Much work lies ahead, but I believe we are off to a very good start, and I look forward to the testimony of our panelists this afternoon.

Before we move to their testimony and the testimony of Secretary Snow, let me turn to the ranking member of this committee, Senator John Breaux of Louisiana. John.

STATEMENT OF SENATOR JOHN BREAUX, RANKING MEMBER

Senator BREAUX. Thank you very much, Mr. Chairman.

I thank Secretary Snow, who I have a great deal of admiration for, a good personal friend of long standing, and always enjoy his presence before our committee, does a great job as our Secretary of the Treasury.

But on the issue before the panel this afternoon, Mr. Chairman, health savings accounts, as they are currently designed, are a terrible idea, whose time has not yet come, and I doubt whether the time will ever come with anybody's life expectancy in this room that it will somehow become a good idea. That is a very strong statement. I opposed it when they did it in the Medicare bill because it does not have anything to do with Medicare. But I oppose it today for two principal reasons:

First, it is totally unprecedented tax policy, folks. If you are looking at 401(k)s or Roth IRAs, we always had a concept in this country that if you are going to have a savings account you can either have it with the contribution to that account deductible up front, and you pay for the buildup when you take it out, or vice versa. This is unprecedented policy that says you are going to be able to deduct it when you put it in and you are going to be able to not have to count as income, the buildup, when you take it out. We have never done that before in any permanent tax savings policy that we have ever had in this country. It is unprecedented. Second, they say, "Well, it is going to be important because if you use it for health care you should not have to pay for the buildup or you should be able to deduct a contribution."

But the type of health policy that it is being used for, Mr. Chairman, is not good public policy, because it is good if you are young, and it is good if you are not going to be sick. But if you are old and happen to be sick every now and then, it is bad policy. The reason I say that I think is quite simple, because the policy, the law says that you have to buy a high-deductible policy. What person that is old and sick and not wealthy is going to buy a high deductible policy? No. 1, they cannot afford a \$2,000 deductible. That is why they are trying to buy insurance. No. 2, they cannot afford to pay for the cost if they are poor.

So I do not want to belabor the point. Obviously, my position is very clear. I think it is terrible tax policy and I think it is even worse health policy. Other than that, I love John Snow. [Laughter.]

The CHAIRMAN. John Breaux and I will not debate the issue here today, but I do believe the American people will prove him wrong.

With that, let me turn to Senator Dole.

STATEMENT OF SENATOR ELIZABETH DOLE

Senator DOLE. Thank you, Mr. Chairman, for providing a forum where we can appropriately discuss the future of our Nation's health care system.

To all of our witnesses today, thank you very much for coming. I realize you made a sacrifice in your busy schedules to be a part of this afternoon's hearing, and your efforts are indeed appreciated.

I want to offer a special thanks to Secretary Snow, who is also my good friend and with whom I have worked on many transportation issues in the past in my years at the Department of Transportation. Thank you for giving us the benefit of your insight today of the most cost effective measures to apply to our health care system.

Sorry, Senator Breaux, another friend of long standing, but I have to disagree with you. There is no question that the Medicare Bill passed by Congress last year created an important new vehicle to help consumers and businesses obtain some relief from soaring health insurance costs.

Millions of Americans, including those who are not even considered seniors, will get help with their out-of-pocket medical expenses through health savings accounts. The benefits of such savings are far reaching indeed. Businesses and individuals who take advantage of these accounts will save substantial amounts on health insurance premiums. Additionally, they will have more control over health care expenditures. These tax-free and convenient accounts will help families pay their medical expenses. They also serve a proactive purpose in that families will have the ability to save for future health care needs. This opportunity to spend less on premiums and save money for the future will greatly aid lower-income individuals and families. Employees and employers can contribute to the HSA, and those funds may be invested in certificates of deposit, money market mutual funds, and other investment vehicles. The bottom line is that HSAs will improve health care access for all Americans. Americans will be able to better control their health care choices and protect themselves from devastating health care costs.

I believe the future of health care looks much stronger thanks to health savings accounts and what they can mean to millions of Americans needing medical care.

Thank you, Mr. Chairman.

The CHAIRMAN. Senator, thank you very much.

Let us turn to our first panelist, Secretary of the Treasury, John Snow. Secretary Snow is a former long-serving chairman and CEO of CSX Corporation, as well as a former administrator of the National Highway Traffic Safety Administration. He brings a wealth of experience both in and out of government, and the country is fortunate to have him serving in this post at this time.

The Treasury Department is charged with the important task of implementing the new health savings account law, and by all accounts, it is handling that task with considerable skill and responsiveness.

Mr. Secretary, we are pleased you are before the committee this afternoon. Please proceed.

**STATEMENT OF HON. JOHN W. SNOW, SECRETARY, U.S.
DEPARTMENT OF THE TREASURY, WASHINGTON, DC**

Secretary SNOW. Mr. Chairman, thank you very much. Senator Breaux, Senator Dole, it is a great pleasure to be here with you to talk about this important new idea in the world of health care.

It is a bold new concept and an awfully important one because it is one of the best single ideas I have seen to deal with one of the most pressing issues America faces, and that is rising health care costs.

I take a particular interest in that subject as Treasury Secretary, because if you look at the budget of the United States what is driving the out-year fiscal situation that the United States will confront is health care costs. There are few things more important for our fiscal future and for the financial soundness of this country in the years ahead. There are a few things as important, maybe nothing as important, as getting our arms around rising health care costs. If we can slow the growth of health care costs from the projected levels of GDP plus 1 percent or GDP plus 2 percent for Medicare, and bring it down by 1 percentage point to GDP level or GDP plus 1, we have an extraordinarily much more benign fiscal future for this country. So we are here dealing with one of the drivers of the financial condition of the country, and probably nothing is more important than this.

Then the question is, how do the HSAs relate to driving down health care costs? As you think about that, it is important to have in mind the American consumer. The American consumer shops. The American consumer knows a bargain. The American consumer weighs alternatives. They go on the Internet. They talk to their neighbors. They carefully consider quality and price in the trade-offs between higher prices and whether you are getting your money's worth. We are good shoppers. We are good shoppers in virtually everything we buy in this country except one thing, health care.

Why are we not good shoppers for health care? Because the consumer is not empowered. Somebody else is making those decisions for the consumer, and the consumer does not see how their own

money is at stake in the decisions they make. It is no mystery, in a situation where consumers are not making tradeoffs, that costs rise. There is no mystery why additional tests are accepted without question when the consumer does not perceive any cost to him of those tests, and when the decisions about those extra tests and extra procedures are being dictated by somebody else.

I think HSAs are a breakthrough idea because it will empower the American health care recipient to make choices, and to shop and search and look for better options, and will give them the ability to do so with those funds that accumulate in the HSA account.

The HSA account is tax advantaged. That is the point of it. The whole point is to create in effect a super-charged IRA for health care, tied to a high deductible. Why do you want a high deductible? I think you know why you want a high deductible. You want a high deductible so that people get a lower premium for their insurance. More people can afford high deductible insurance than insurance that is not high deductible, so you encourage more people to get into the use of these beneficial insurance plans. But when you think about insurance, your house insurance does not include the coverage of, say, a washer going out on the sink. It covers the catastrophic expense. It covers the heavy cost. Your auto insurance does not cover the muffler going out. It covers significant incident to the automobile itself. It seems to me we need to be moving health care in that same direction so that consumers are empowered, they get lower cost and real insurance, and they are empowered to make decisions. The result of all that, I am confident, will be broader health care coverage and lower long-term health costs.

I thank you very much.

The CHAIRMAN. Mr. Secretary, thank you. There is no question that what we are doing is innovative. It is different, and obviously, my friend and colleague Senator Breaux is reacting to that, probably because it is new and yet to be determined. At the same time, it appears that the market is ripe for this. So let me ask a couple of questions of you in light of what some of the critics are saying.

Critics of HSAs are fond of predicting that they might promote adverse selection, for example, by attracting predominantly healthier and wealthier enrollees. Yet the actual claims based data that is available suggests really quite the opposite, namely, that consumer choice approaches, like HSAs, actually show virtually no evidence of adverse selection. What is the Treasury's assessment of this issue?

Secretary SNOW. Mr. Chairman, we have looked at that contention that the HSAs would lead to adverse selection, and have found no evidence to suggest that that is the case or would be the case. The Federal Employees Health Benefit Program (FEHBP) has available to it, as you know, a high deductible plan. A High deductible plan option has been made available. This is a test case of whether or not adverse selection would occur, and whether just the young and the healthy would opt for it. That has not been the case in the FEHBP.

I think the HSA with the high deductible is a new option that will be used by people in all income classes, and people of diverse health status.

The CHAIRMAN. Many say that HSAs offer a real lifeline to employers struggling to continue providing insurance to their employees, as well as to the currently uninsured who are looking for affordable coverage. What do you believe will be the effect of the new HSAs on both the employer health market and on the number of the uninsured that many of us are concerned about in our States?

Secretary SNOW. I think it is going to reduce the number of uninsured, and I think it will help small business employers continue coverage or extend coverage. When the President was out in Minnesota a month or so again on the HSAs, he met with Dan Schmidt, who is owner of the Mercury office Supply Company in Minnesota, a company that had 12 or 13 employees. It is a small office supply retailer. Their premiums in 2004 were due to increase to \$36,000. Mr. Schmidt became aware of the opportunities for the HSAs, and he looked into it. He was confronted with the possibility, the real possibility of dropping his health care coverage because he could not afford the \$36,000. By opting for the HSA—and this is a real life story—the premiums came down to \$24,000. He saved that roughly \$12,000, and he used it to fund the employees' HSA with a no co-pay plan. So there is a real life story of how HSAs coupled with the high deductibles can help a small business person reduce the cost of health care and take the savings on the premiums and fund the HSA accounts themselves. I think that is a story that we are going to see told over and over and over again in the months ahead.

The CHAIRMAN. I thank you.

Let me turn to my colleague, John Breaux. John.

Senator BREAUX. Thank you, Mr. Chairman.

Thank you, Mr. Secretary, for being with us.

I agree with the first part of your statement that it is a bold and new idea. I would just add that it is a bold, new and bad idea. If you are healthy and you are wealthy, it is a great idea, but if you are low income and likely to get sick, for anyone to say, I am going to go out and buy a \$2,000 deductible policy is not a good idea. It may be new, but it is not good.

My point is, you talked about good shoppers, Mr. Secretary. If this is such a good deal from a shopper's perspective, why is it necessary for us to spend \$16 billion of tax dollars, which is what the Treasury Department says it is going to cost the Government to institute HSAs? If it is such a good idea, why do people not just go out and buy it? Why do we have to subsidize it to the tune of \$16 billion to make it such a good idea to probably get people to buy it?

Secretary SNOW. In order to encourage people to have these accounts, and the accounts then buildup and become the vehicle for people making their own health care choices, and—

Senator BREAUX. I agree with that. But why do we have to spend \$16 billion to encourage it if it is already a good idea? Will it not fly on its own, that we have to spend \$16 billion subsidizing it?

Secretary SNOW. Senator, we want to encourage—

Senator BREAUX. That is a lot of encouragement.

Secretary SNOW [continuing]. This sort of behavior. But the other end of that encouragement is the potential to sharply reduce long-

term health care costs which is a multiple of whatever the tax cost would be I would submit.

Senator BREAU. You pointed out that a high deductible—like if I am young, if I am my son, who is very healthy and very young, and making a very good income, more than his dad, I mean this is a great idea. I am going to take a high deductible because I have not been to the doctor, I do not get sick, and boy, I am going to save a lot of money and it is a great idea. But if I have a low income and I am a poor person who has chronic illnesses, this would be a very terrible idea, and it seems to me that given the choice, if you take young people who are not sick, and they all run to the HSAs, and they leave comprehensive regular insurance, who is left? People who are going to be left under the comprehensive policy are going to be people that are older with chronic conditions and who are low income, who cannot afford high deductible policies. That is where the adverse risk is, that is the history of insurance, and that is how adverse risk selection occurs.

I just cannot—you talk about, well, the high deductible is normal because home policies does not cover washing machines and mufflers. But you can live without a muffler, and you can live without a washing machine, but you cannot live without health care, and that is what we are talking about. That is why it is such a bad idea. You can comment on that.

Secretary SNOW. Senator, we believe there will be more people covered, more people covered, not fewer, with health insurance as a result of the HSA being in place, and there will be many Dan Schmidts of the world, who are small owners and managers of small businesses, who will be able to sustain health care insurance for their employees, or expand it, because of the savings that are implicit here in their being able to move to the high deductible plans, take the savings and put them in to the fund the HSAs.

Senator BREAU. It is all right if Ann Smith wants to do it on her own, but is it such a bad idea that we have to subsidize it with \$16 billion to get Ann Smith to do it? I mean if it is that good of an idea, the Ann Smiths of the world ought to do it on their own. You talk about studies from Treasury. There are studies from the RAND Corporation, the Urban Institute, the American Academy of Actuaries, that found that premiums for comprehensive insurance could more than double, could more than double if the whole concept that we are talking about here becomes widespread and everybody flocks to these new type of policies. That is my concern.

Secretary SNOW. Senator, let me just conclude here where I started, and that is an issue you know well, better than I, better than most people, and that is the critical need to find some way to deal with this huge fiscal obligation in the years ahead that grow out of the unfunded promises of which the biggest is health care. If we are going to keep our commitments, and if we are going to do it in a way that is fiscally sound, we have to find ways to lower the growth rate of health care cost.

This is a proposal that many experts feel will help achieve that objective.

Senator BREAU. I would just argue that this has absolutely nothing to do with slowing the cost of health care. It just moves a lot of healthier and wealthier people into one type of insurance.

It would not be a bad idea if we make that available to them, which it already is available, but that the Government does not have to subsidize it.

You are doing a fine job with a bad idea.

Thank you.

Secretary SNOW. Thank you, Senator.

The CHAIRMAN. Obviously, the other point of view has been clearly heard, and John is well spoken on this issue. I would comment that it is interesting that we make the assumption that—and John used the example of his son. I have a son also who is struggling at this moment with his wife to have adequate health care coverage. One of their employers just changed their policy because of the cost, and costed them out of the market and so one of them got dropped from that policy, and they are in the market now searching for something they can afford.

They are both working. They both have excellent jobs. But their employer tipped them upside down on insurance because the employer can no longer afford to offer what they had been offering. Whether HSAs will be an option for them or not, it certainly is an opportunity, and I have walked them through it as an example. Once these vehicles become available, they are going to take a look at it, see whether it fits them or not.

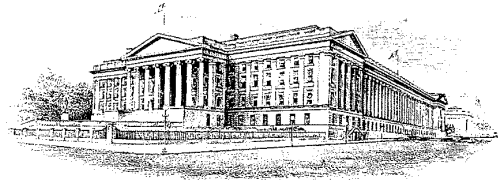
Let me ask you this, John. Although it is not a focus of today's hearing and it is a separate issue from an HSA in general, I am interested in the administration's current proposal to go a step further to create tax deductibility for premiums, the premiums consumers pay on high deductible plans purchase in conjunction with an HSA. In what way do you believe this proposal will benefit health care consumers and improve health care access?

Secretary SNOW. Anything that encourages the use of the high deductible health plans is a move in the right direction. A larger market, an expanded market for high deductible health plans will bring more people under health care coverage, under insurance coverage, and it will create the right incentives for people to think hard about the choices they confront in purchasing health care services.

What we really need to do I think here, Senator, Mr. Chairman, is to empower the American health care recipients to be good consumers, and the more we do that, I am confident we will see the health care system responding with higher quality and lower cost, and that is the objective. They get better quality and lower cost, a more efficient health care delivery system, and I think it is perfectly appropriate, in fact, it is something to be encouraged here, and that is precisely what the deductibility provision that the President sent to the Congress in this year's budget would do. It would lower the cost by having an above-the-line deduction on the premium for the high deductible health plan which is something very much to be encouraged.

The CHAIRMAN. Mr. Secretary, again, we thank you very much for your presence here today and the work that is going on in Treasury right now to move this concept to the marketplace, and then both John and I will watch it I am sure very, very closely over the coming months and years to see where it takes us in health care, and whether it offers what some of us believe it can.

Again we thank you.
Secretary SNOW. Thank you very much.
[The prepared statement of Secretary Snow follows:]



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May 19, 2004

Contact: Tara Bradshaw
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Hearing Testimony
The Honorable John W. Snow
Secretary of the Treasury
On the Benefits of Health Savings Accounts (HSAs)
Before the Special Committee on Aging
United States Senate
May 19, 2004

Chairman Craig, Ranking Member Breaux and distinguished members of the Committee, thank you for the opportunity to testify before you today on the benefits of Health Savings Accounts (HSAs).

On March 16th, the President joined several small business owners to discuss health care costs and what the federal government can do about them. Dan Schmidt was one of those participants. He owns Mercury Office Supply, a Minnesota office supply retailer with 13 employees. For 2004, Mercury's annual health care premiums were set to increase to \$36,000. Dan says he considered dropping coverage for his employees.

Instead, he was the first to sign up for the group HSA plan provided by Prime Health Care. The plan became effective on January 1, 2004. With the HSA, Dan's new premiums were just \$24,500, saving Mercury approximately \$11,500 this year. Dan is using the savings to help fund his employees HSA accounts. Dan's employees now have the coverage that they need and more control over their health care spending.

Mr. Chairman, there are thousands of employers like Dan across this country who have signed up for Health Savings Accounts in the few months they have been available. HSAs were part of the Medicare bill passed by Congress and signed by President Bush on December 8th of last year.

As Dan's example demonstrates, these accounts signal a historic change in the way we look at health care. The themes you hear from Dan and other HSA participants are consistent – they talk

about lower costs, increased control, and the ability to plan for the future. HSAs reduce insurance costs, enabling more employers to begin or retain health insurance benefits for their employees. They give people more control over who they see for health care services. And they encourage saving for future medical expenses, including retiree health expenses.

The advantages of HSAs are numerous:

- HSAs encourage savings for future health care needs. Earnings from HSA balances accumulate tax free. Distributions are tax free as well, as long as they are used to pay for qualified medical expenses.
- HSAs provide people the resources they need to access health care. Individuals and their employers both can contribute pre-tax dollars into the accounts. Contributions are limited to the insurance policy's annual deductible, subject to a cap of \$2,600 for individuals and \$5,150 for families. Individuals aged 55-64 can make additional catch-up contributions.
- HSAs are flexible. The accounts can pay for health insurance deductibles and co-payments for medical services, products, and prescriptions. They can pay for over-the-counter drugs, long-term care insurance, and health insurance premiums during any period of unemployment. They can also pay for out-of-pocket expenses under Medicare, including premiums for Part B and the new drug benefit (Part D).
- HSAs improve upon Archer Medical Savings Accounts (MSAs). HSA are available to everyone, not just the employees of small business and the self-employed, and there is no limit on the total number of policies.
- HSAs are portable. Workers who move from job to job take the account with them, just like an Individual Retirement Account. The HSA is also owned by the individual, not the employer, and goes with the individual in the event of a job change.

HSAs put individuals in charge of their health care purchasing decisions. Consumers often find traditional health insurance plans frustrating because it sometimes feels like decisions about their health are being made by other parties...not themselves. With an HSA, health care decisions are made by the individual and their health care provider – nobody else. HSAs increase the ability of individuals to make decisions that are in their own best interest.

HSAs also give consumers the opportunity to budget for their health expenses over many years. HSA balances roll over from year to year, allowing consumers to build up money in their accounts when they have low health care needs, leaving them with more money to cover out-of-pocket expenditures when the need arises.

The President's budget would further expand the availability of HSAs by allowing taxpayers an above-the-line deduction for insurance premiums associated with HSAs. This proposal would give individuals the same tax advantage that employers and the self-employed enjoy today when purchasing health insurance. This would be an important step in ensuring that the advantages of HSAs are not limited only to employer-provided health insurance.

One of our greatest challenges with HSAs is getting the word out and helping people understand how they work. Among other efforts, we have a page on our website dedicated to HSAs that

includes "Frequently Asked Questions." We also set up an e-mail address – hsainfo@do.treas.gov – as well as a voice mailbox: 202-622-4HSA, where individuals can submit questions.

For those in the insurance and financial community, the Treasury Department is engaged in offering a series of guidance from the IRS on some of the more pressing questions. We issued our first guidance in December, just a few weeks after the enactment. At that point we asked the public to comment and help us resolve any outstanding issues.

On March 30th of this year, we issued guidance covering the definition of "preventive care" and detailing how prescription drugs fit within the definition of the high-deductible health plan that must accompany an HSA. And just last week, we issued guidance that outlined how an employer could successfully integrate an HSA program with flexible spending arrangements and health reimbursement arrangements.

There are still issues outstanding, and we want to make sure both communities – those who offer and those who use HSAs – have all the guidance they need. In June, we hope to issue the next set of major guidance to further clarify how these accounts will work.

It should also be noted, Treasury is working extensively with others in the Administration to promote the availability of HSAs. The Small Business Administration, for example, has participated in the release of our previous guidance and is helping to spread the word among small business owners throughout the country by use of roundtables and other events. The Office of Personnel Management has asked health insurance carriers participating in the Federal Employees Health Benefits Program (FEHBP) to develop HSA plans for the 2005 benefit season. The Department of Labor recently issued guidance making clear that HSAs generally will not constitute an employee benefit plan under ERISA.

We will continue to work closely with those who, like we at the Treasury, are interested in making sure HSAs are available to individuals and employers across the country. For this reason, it is encouraging to see a wide variety of business and consumer interest groups – from the Hispanic Business Roundtable to the National Federation of Independent Business and the 60 Plus Association -- take a strong and active interest in HSAs.

I truly believe we will look back on the creation of Health Savings Accounts as a giant step forward in our efforts to ensure Americans have increased access to the health care services they need.

Again, thank you for the opportunity to be here today. I look forward to answering any questions you may have.

The CHAIRMAN. Let me invite our second panel to the table. I think this group will represent a range of different perspectives and constituencies on health care savings accounts.

Our first witness on the second panel today will be John Goodman, president of the National Center for Policy Analysis. Perhaps more than any other individual, Dr. Goodman has devoted much of his professional life to pursuing consumer choice in health care. I think it is no surprise that many have called him the father of medical savings accounts. We are pleased you are able to be with us today.

Our second panelist is Ron Williams, the president of Aetna. Aetna has been a market leader in consumer-directed health care, both as an insurer offering consumer choice products and as an employer offering such products to its own employees.

Next we have Kate Sullivan, executive director of Health Policy at the U.S. Chamber of Commerce. She is a recognized expert on consumer choice on health care and has been among the leaders guiding the Chamber's strong support for health savings accounts.

Next we have Edward Langston he is a trustee of the American Medical Association with a longstanding service to that organization, and is also a practicing family physician in Lafayette, IN.

Robert Greenstein is the founder and executive director of the Center on Budget and Policy Priorities. He has been invited today at the invitation of our Minority, and will bring I think a critical voice to the health savings account issue.

We are pleased all of you can be with us today. Dr. Goodman, we will start with you.

**STATEMENT OF JOHN C. GOODMAN, PH.D., PRESIDENT,
NATIONAL CENTER FOR POLICY ANALYSIS, DALLAS, TX**

Mr. GOODMAN. Thank you, Mr. Chairman, Senator Breaux.

Prior to this year the tax law generously subsidized employer payments for third-party health insurance, but it severely penalized any type of self insurance so that individuals could pay their own medical bills from a savings account. Every dollar of premiums that an employer paid to, say, Blue Cross/Blue Shield, avoided income and payroll taxes, and for a middle income family, that means the Government was effectively paying for half the cost of the insurance. Yet if the employer tried to take that same dollar and put it in a savings account so that the employee could pay his medical bills directly, the Government taxed the dollar before it got into the account. For a middle income employee, this means the Government was taking half the money before it went into the account. This is exactly what happened to us at the National Center for Policy Analysis.

In effect, what the tax law was doing was encouraging us to give all our health care dollars to a third-party payer and let that third-party payer determine how the money is spent, instead of allowing patients and their doctors to make these decisions.

The new law, and I think this is the answer to Senator Breaux's question, the new law creates a level playing field, treating third-party health insurance and self insurance in exactly the same way. I will say parenthetically that this is not the only way to do it. I have proposed other ways of doing it. But what is important is that

however we treat third-party insurance we need to treat self insurance exactly the same way. The new law will allow individuals to manage some of their own health care dollars in accounts that they own and control, and decisions about which bills are going to be paid indirectly by patients and which bills would be paid by insurers will be determined by individual choice in the marketplace, and not by the tax writing committees of the Congress.

This new opportunity will revolutionize the medical marketplace in my opinion. We are about to unleash a vast army of people who understand or will understand that when they spend a dollar in the medical marketplace, it is their dollar and not someone else's dollar. These are people who when they spend a dollar are going to insist on a dollar's worth of value. We are about to have millions of savvy consumers who fully understand that when they spend a dollar on health care, that is a dollar not available for something else, and who, acting in their own interest, will make their own choices between health care and other uses of money.

We are about to give thousands of doctors the freedom to act as agents of their patients, rather than acting as agents for third-party payers. We are about to create opportunities for thousands of entrepreneurs who will discover myriad ways to profit by delivering health care more efficiently. We are about to take a very small step in the direction of a very important social goal, and that is making employee benefits personal and affordable.

The critics of all of this have been remarkably consistent over the past 15 years. Many of them quote each other. They cite each other. They repeat each other as though they were in some sort of echo chamber. Many of the critics are good honest people who I have talked to, but nonetheless admit that they have never had a health savings account of their own, they have never seen one, they do not know anyone who has one. If you scan the footnotes of Mr. Greenstein's testimony today what you will find are a lot of references to simulation and speculation, but there is not one reference to a study of the behavior of real people. It turns out that such studies really do exist and more information is becoming available every day.

We now have a decade of experience with medical savings accounts in South Africa, where two-thirds of the people with private health insurance there now have medical savings account plans. We have 7 years of experience with the medical savings account pilot program in this country, and we have 2 years of experience where the health reimbursement arrangements are HRAs. What is evident from all of this experience is that the evidence is strong and consistent and coming from many different sources.

First, savings accounts change behavior. When it is their own money, people see physicians less often, they buy fewer drugs, they substitute generics for brand names. They save money. Second, they manage to do it in a way that is not harmful to their health. Third, the health savings accounts, contrary to all the claims of all the critics, do not just appeal to the young and the healthy and the rich. In fact, if anything, it tends to be slightly in the other direction—the health savings account population tends to be a little bit older, a little bit less healthy, a little bit less rich. Fourth, the health savings account holders do not skimp on preventive medi-

cine. In fact, under some of the most popular plans in the United States and in South Africa, people tend to get a little bit more preventive medicine when they are managing their own money than when they are in a conventional plan.

Finally, I do not know of any evidence of employers using the medical savings account or health savings account opportunity to cut back on benefits. To the contrary, these plans are proving to be uniformly popular with employees. When employers have asked employees to vote on this, they uniformly, by a large majority, say that they want to keep their health savings account plan. They do not want to go back to some conventional plan.

I will conclude, Mr. Chairman. The idea is, good for the pocket, good for our health, and good for the country.

[The prepared statement of Mr. Goodman follows:]

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Statement

on

Health Savings Accounts

by

**John C. Goodman, Ph.D.
President
National Center for Policy Analysis**

**Testimony
Before the
U.S. Senate Special Committee on Aging**

May 19, 2004

Introduction

As of January 1, 2004, 250 million nonelderly Americans now have access in principle to Health Savings Accounts (HSAs), provided they are combined with catastrophic insurance. The idea behind HSAs is quite simple. Individuals should be able to manage some of their own health care dollars through accounts they own and control. They should be able to use these funds to pay expenses not paid by third-party insurance, including the cost of out-of-network doctors and diagnostic tests. They should be able to profit from being wise consumers of medical care by having account balances grow tax free and eventually be available for nonmedical purchases.¹

Reforming the Health Care System

HSAs have the potential to inaugurate fundamental reform in the way health care is practiced in this country.

Creating a Level Playing Field between Third-Party Insurance and Individual Self Insurance. Health Savings Accounts are designed to help correct a major flaw in tax law that distorts the entire health care system. Every dollar an employer pays for employee health insurance premiums avoids income and payroll taxes. For a middle-income employee, this generous tax subsidy means that government is effectively paying for almost half the cost of health insurance. On the other hand, the government previously taxed away almost half of every dollar employers put into savings accounts for employees to pay their medical expenses directly. The result was a tax law that lavishly subsidized third-party insurance and severely penalized individual self insurance. This has encouraged consumers to use third-party bureaucracies to pay every medical bill, even though it often makes more sense for patients to manage discretionary expenses themselves.

The new law, part of the recently-enacted Medicare prescription drug bill, gives deposits to HSAs the same tax advantages formerly granted only to health insurance premiums. Employer and employee deposits to HSAs will avoid all federal income and payroll taxes. When combined with individually owned insurance, HSA deposits will be a deductible expense, even for income tax filers who do not itemize. The insurance premiums, however, are not deductible unless the purchaser is self-employed.

Making Choices. Medical research has pushed the boundaries of what doctors can do for us in every direction. As a result we could probably spend the entire gross domestic product on health care in useful ways:²

- The Cooper Clinic in Dallas now offers a comprehensive checkup (with a full body scan) for about \$2,500. If everyone in America took advantage of this opportunity, we would increase our nation's annual health care bill by one-half.
- There are more than 900 diagnostic tests that can be done on blood alone, and one doesn't need too much imagination to justify, say, \$5,000 worth of tests each year. But if everyone did that we would almost double the nation's health care spending.

- Americans purchase nonprescription drugs almost 12 billion times a year and almost all of these are acts of self-medication. Yet if everyone sought a physician's advice before making such purchases, we would need 25 times the current number of primary care physicians.³
- Some 1,100 tests can be done on our genes to determine if we have a predisposition toward one disease or another.⁴ At, say, \$1,000 a test, it would cost more than \$1 million for a patient to run the full gamut. But if every American did so, the total cost would be about 30 times the nation's total output of goods and services!⁵

Notice that in hypothetically spending all of this money we have not yet cured a single disease or treated an actual illness. In these examples, we are simply collecting information. If in the process we actually found something that warranted treatment, we could spend even more.

So how do we decide which procedures are worthwhile and which are not? There are basically only three ways. In other developed countries, these decisions are made either directly or indirectly by government. But government-imposed rationing is arbitrary, inefficient, unfair and probably unacceptable to most Americans. The second method is to restrain spending using managed care techniques. But during the 1990s voters expressed discomfort with having employers and large insurers ration their health care. The third option is to allow individuals to make their own choices between spending on health care or needs, through a vehicle such as HSAs.

Restoring the Doctor-Patient Relationship. In a managed care world, doctors too often look to employers and insurers for direction in the practice of medicine. In a very real sense, providers view insurers rather than patients as their customers. For example, if a patient is covered by Blue Cross, providers tend to view Blue Cross rather than the patient as the real buyer of care. How symptoms are treated, what tests are ordered, what follow-up procedures are indicated—all such decisions tend to be heavily influenced by Blue Cross guidelines rather than the wishes and needs of individual patients. Similarly, for Medicare patients, Medicare is the real buyer of care; for Medicaid patients, the buyer is Medicaid, etc.

With HSAs, patients become the primary buyers of health care services with the right to compare prices and treatments, and to make decisions. Doctors are free to serve as the principal agents of patients and advise them on options—helping them make informed decisions. However, physicians must be more than medical agents of their patients. They must become economic agents as well—helping patients minimize the cost of high quality care. Patients will make better choices if they can rely on doctors who put their medical and economic interests first.

Creating Portability. One disadvantage of employer-based insurance is that employees must switch health plans whenever they switch employers. In the old fee-for-service days, this defect imposed less of a hardship because employees were generally free to see any doctor under any plan. Today, however, changing jobs often means changing doctors as well. For an employee or family member with a health problem that means no continuity of care. Because HSA funds are portable, they can travel with employees on their journey through the labor market. They are a step in the direction of truly portable health insurance coverage.

Ten Advantages of Health Savings Accounts¹

Saving Money. When people purchase medical care with funds in a HSA, they are spending their own money rather than someone else's. As a result, they tend to become careful, prudent consumers in the medical marketplace.

Restoring the Doctor-Patient Relationship. Bureaucratic efforts to control costs often interfere with the doctor-patient relationship. With HSAs, patients and doctors are encouraged to manage the care.

Maintaining the Quality of Care. Bureaucratic efforts to reduce costs can also threaten the quality of patient care. To the degree that patients are spending their own money, and doctors are free to act as the agents of their patients, there are natural forces in place to maintain quality.

Encourage Rationing by Choice. Unless someone makes the difficult choice between medical care and other uses of money, we could spend the entire GDP on health care. HSAs allow individuals — rather than large, impersonal bureaucracies — to make those decisions.

Creating a Competitive Marketplace. Most patients cannot discover the price of even routine procedures before entering a hospital and cannot decipher the bill when they are discharged. But with HSAs, a single package price stated in advance will become the norm as is the case with cosmetic surgery in the United States and privately paid surgery in England.

Providing Funds for Preventive Care. HSAs are source of funds for services not covered by third-party health insurance.

Providing Funds for Health Insurance Premiums. HSAs provide funds to continue health insurance coverage when people are unemployed.

Providing Funds for Long Term Care. HSA funds not spent during a person's working years will be available for long-term care, long-term care insurance and other post-retirement medical needs not met by Medicare.

Creating Real Insurance. With HSAs, health insurance will be likely to resemble casualty insurance in other markets — paying for risky, unforeseen, costly medical episodes and allowing individuals to pay directly for other forms of care.

Creating Personal and Portable Employee Benefits. HSAs will be the private property of the individual account holder. Their establishment would be a movement in the direction of a worthwhile social goal: making all employee benefits personal and portable.

¹ See John C. Goodman and Gerald L. Musgrave, "Personal Medical Savings Accounts (Medical IRAs): An Idea Whose Time Has Come," Policy Backgrounder No. 128, National Center for Policy Analysis, July 22, 1993, p. 3.

Advantages and Disadvantages of Other Types of Savings Accounts.⁶ Besides Health Savings Accounts (HSAs), several well-known mechanisms for consumer-directed spending are Flexible Spending Accounts (FSAs), Medical Savings Accounts (MSAs) and Health Reimbursement Arrangements (HRAs).

Medical Savings Accounts. These accounts became available to small businesses and the self-employed through a 1996 pilot program. Unfortunately, Congress imposed restrictions on MSAs that limited their appeal. For example, they were restricted to the self-employed and to small employers who were the least likely to offer health insurance to their employees. Although employers usually funded MSAs, the size of the deductibles and MSA deposits were unduly restricted. Because of the short duration of the pilot project, as well as the cap on the number of participants, few insurance companies were interested in competing for a limited market. Due to these many restrictions, only about 70,000 people were able to take advantage of these accounts.

Flexible Spending Accounts. These accounts offer employees the chance to set aside funds tax free for medical care. Employees with FSAs usually fund these accounts through pretax deductions from their paychecks.⁷ However, the popularity of these accounts is limited by restrictions on their funding and use. For example, FSAs have a use-it-or-lose-it provision. The law requires employees to forfeit any unused funds at the end of the year, even though they had to decide at the beginning of the year how much to deposit each month. Failure to accurately predict their health care spending means sacrificing the end-of-year balance or engaging in last-minute spending on items of marginal value.⁸ This forfeiture provision encourages employees to waste money on unnecessary care and makes most people apprehensive about depositing money except when they can precisely predict their future medical needs. This is one reason why, of the estimated 29 million employees with access to such accounts, only about six million use FSAs to pay medical bills. Far more use the accounts solely to pay their portion of health insurance premiums.

Although FSA deposits are made from the employee's paycheck, employees do not really own their FSAs. Not only is the account balance forfeited at year's end or with a change in jobs, the employee's heirs are not entitled to the funds in case of death. These restrictions need to be changed. On May 12, 2004, the House of Representatives passed a bill that would allow individuals to roll over up to \$500 of unused FSA account funds to the following plan year or to move it into an HSA for use in the next year.⁹ Employees should also have other options for saving unspent FSA balances, including rolling over accumulated balances into other tax-deferred accounts — MSAs, IRAs, 401(k)s and 403(b)s.

Health Reimbursement Arrangements. These are another type of personal account from which employees can pay directly for their medical care. A U.S. Treasury Department ruling in 2002 clarified that employer deposits to HRAs are not taxable employee compensation and can be rolled over from year to year. A number of large companies have established such accounts,¹⁰ and at last count, 1.5 million employees had enrolled.¹¹

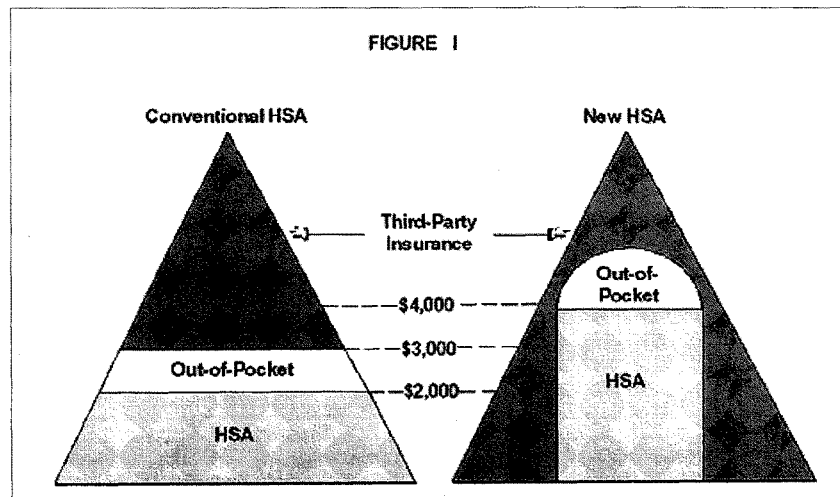
Unfortunately, these accounts also face unreasonable restrictions.¹² Currently HRA funds must be spent only on qualified medical services. This means employees can never withdraw their HRA funds as cash for nonmedical uses and that they are barred from choosing between health care and other uses of the money.

Making HSAs Better

In principle, 250 million Americans are eligible to establish Health Savings Accounts. But because of restrictions imposed by Congress many will not be able to do so. Congress required that HSAs be accompanied by a traditional indemnity insurance plan with a specified deductible and specific limit on total out-of-pocket expenses. Less restrictive HSAs would allow individually tailored insurance to serve the needs of each patient, rather than imposing a one-size-fits-all solution.

HSA Design. The left side of Figure I illustrates the most common design of HSAs in employer plans. The plan pays all costs above a deductible of, say, \$2,000. The HSA deposit in this example is \$1,000. Thus the employee pays the first \$1,000 of medical expenses from the HSA and the next \$1,000 is paid out of pocket. Any remaining costs are paid by the plan.

However, this is not necessarily the ideal way to design HSAs. The design pictured on the right side of Figure I is preferable because the plan pays first-dollar for some treatments, while leaving the insured free to pay higher amounts for other services. For instance, it makes little sense to require high deductibles for hospitalization since this is likely beyond the control of patients. Likewise, offering first dollar coverage (or lower deductibles) for chronic illnesses might improve compliance and save money over the long term.



The South African Experience. In South Africa, beginning under the administration of Nelson Mandela, Medical Savings Accounts (MSAs) became available that could be combined with any form of third-party insurance. These MSAs are similar to the new HSAs in the United States, but without restrictions.

In South Africa, MSA plans have captured about two-thirds of the market for private health insurance. However, the most popular plans in that country are not allowed under the rigid parameters set for the U.S. market.

In the United States, federal law dictates what the insurance contract must look like. In particular, the health insurance policy that accompanies an HSA must have an across-the-board deductible of at least \$1,000 for an individual or \$2,000 for a family, with exceptions for preventive care.

In a typical South African plan there is no deductible for hospital care, on the theory that patients are exercising very little discretion in a hospital setting. By contrast, there is roughly a \$1,200 deductible for out-patient care on the theory that patients exercise a lot of discretion with respect to those services.

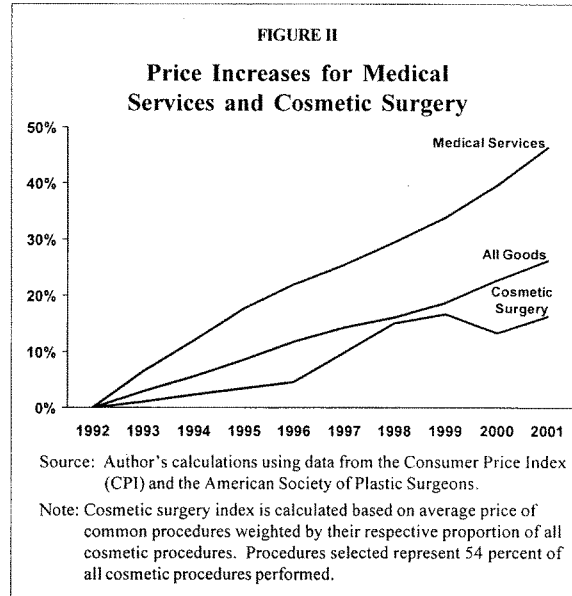
Most drugs also face a high deductible. When the insurer wants to encourage drug therapies, however, the deductible may drop back to zero. This flexible approach encourages patients to make prudent choices when patient discretion is appropriate, but not when discretion is inappropriate.¹³

There are also other interesting innovations. For example, diabetics can enroll in a center of excellence for diabetic care. They pay one-third of the cost from their MSA, while the employer (or insurer) pays the other two-thirds.

Case Study: Cosmetic Surgery¹⁴

Cosmetic surgery is one of the few types of medical care for which consumers pay almost exclusively out of pocket. Even so, the demand for cosmetic surgery exploded in recent years. Of the 6.6 million cosmetic procedures performed in 2002, 1.6 million were surgical procedures, nearly four times the number performed in 1992. Despite the quadrupling of the number of surgeries, cosmetic surgeons' fees remained relatively stable. The average increase in prices for medical services from 1992 through 2001 was 47 percent. (See Figure II.) The increase in the price of all goods, as measured by the Consumer Price Index (CPI), was 26 percent. Cosmetic surgery prices went up about 16 percent. Thus, while the price of medical care generally rose almost twice as fast as the CPI, the price of cosmetic surgery went up less than two-thirds as much. Put another way, while the real price of general health care rose, the real price of cosmetic medicine fell.

What explains this price stability? One reason is patient behavior. When patients pay with their own money, they have an incentive to be savvy consumers. A second reason is supply. As more people demanded the procedures, more surgeons began to provide them. Since almost any



licensed medical doctor may obtain training and perform cosmetic procedures, entry into the field is relatively easy. A third reason is efficiency. Many providers have operating facilities located in their offices, a less expensive alternative to outpatient surgery at a hospital. Surgeons generally adjust their fees to stay competitive and usually quote patients a package price. Absent are the gatekeepers, prior authorization and large medical office billing staffs needed when third-party insurance pays the fees. A fourth reason is the emergence of substitute products. For example, cheaper procedures designed to reduce the appearance of aging have held the cost of facelift surgery in check. These include laser resurfacing, Retin-A treatments, botox injections, collagen injections, chemical peels, dermabrasion and fat injection. These less invasive (and less expensive) procedures may be attractive, compared to a facelift costing \$5,000 or more in surgeons' fees alone.

Cosmetic surgeons also have incentives to find new products to meet customer needs. Laser hair removal, for example, is now common.

Answering the Critics of Health Savings Accounts

Despite the fact that both economic studies and common sense suggest that patient power reforms are needed and desirable, there has been a steady stream of critics, repeating claims made more than a decade ago and seemingly impervious to a mountain of evidence that refutes them.

Will personal health accounts control costs? There is abundant evidence that HSAs change patient behavior and that those changes help control costs. A study of South African employees covered by Discovery Health Medical Savings Accounts plans found that:¹⁵

- Relative to those in non-MSA plans, MSA families reduced their health care spending significantly, ranging from a 56 percent reduction for families in which the head of household is relatively young to a 47 percent reduction for the elderly.
- On average, joining an MSA plan induces people to cut their discretionary spending by more than half.

A follow up study focused specifically on prescription drug costs. Among the findings:¹⁶

- Those purchasing prescriptions with insurance company money spent 7.1 percent more per prescription filled, and they filled 19.1 percent more prescriptions per month.
- Overall, those using insurance spent 27.6 percent more per month on prescriptions than those using a Medical Savings Account.

Preliminary evidence from the U.S. experience with HRAs suggests that we are experiencing similar cost control behavior. Employees with personal accounts tend to reduce the number of physician visits, switch from brand name drugs to generics and take other actions to reduce waste and inefficiency in health care consumption.¹⁷

Will personal health accounts encourage people to forgo needed care? Critics worry that people with HSAs will skimp on needed medical care in order to save money.¹⁸ There is no evidence of this. In fact, the evidence shows that when people take responsibility for their own health care, they fare just as well as others.

HSAs have only been available for a few months in the United States, but we do have evidence from experience with HRAs. Employee behavior differs depending on the specific design of the health plan. That said, in several popular plans employees received more preventive care than those enrolled in traditional health insurance.

For example, enrollees in Definity Health's HRA plans received preventive care that met or exceeded widely-accepted standards of care — including several types of diabetes preventative testing, mammograms and medications to control asthma.¹⁹ In fact, those enrolled in HRAs tended to participate in more preventive care than a control group.²⁰

Among enrollees in Aetna HealthFund's HRA plan, preventive care office visits increased by 30.1 percent compared to a 14 percent increase for a similar population.²¹

Members of Destiny Health's HRA plan also receive preventative care at higher rates than traditional health insurance enrollees. They are more than twice as likely to say that lifestyle choices directly impact health care costs. Consequently, they were 147 percent more likely to participate in a wellness or nutrition program in the last year. They are more than twice as likely to have educated themselves about their health plan as members of other plans.²²

These findings are consistent with the classic RAND Health Insurance Experiment which randomly assigned people to high-deductible plans. This research found that both groups (that is, high and low-deductible cost sharing) had similar outcomes even though those in high-deductible plans spent less on health care.²³

Will personal health accounts appeal only to the healthy young people? Some of the critics of personal health accounts often argue that they will experience favorable selection by appealing only to the “young healthy” — leaving older, sicker individuals in traditional risk pools.²⁴ However, preliminary data show that the average age of Aetna’s HealthFund HRA enrollees is slightly higher than in other plans, not lower as critics suggest. Overall, about two-thirds of HealthFund enrollees were between the ages of 35 and 55.

Will personal health accounts encourage employers to cut benefits and move employees into unpopular stripped down health plans? Employers do not need an excuse to cut benefits.²⁵ They provide health benefits to retain a competitive workforce. Where provided, health benefits are a nontaxable form of compensation. Employers do not “give” employees health benefits, employees accept health benefits in lieu of wages. For a given expenditure, it is in the employer’s self-interest to choose a compensation package that is most attractive to employees.

In fact, enrollees in HRA plans have expressed a high degree of customer satisfaction. Ninety percent of those enrolled in Aetna’s HRA plans reported satisfaction with their choice and were likely to renew for the following year.²⁶ In Definity Health’s HRA plan, only about one percent to two percent reported being very dissatisfied.²⁷ Almost three-quarter of Destiny Health members agreed that consumer driven plans are better than managed care, compared to only about one-third of enrollees in other types of health plans.²⁸

Will personal health accounts force patients to pay higher prices for medical care? Critics of HSAs often claim they will be inefficient because cash-paying customers will pay “retail” while HMOs pay “wholesale.” But in virtually all HSA plans, patients spending from their account pay the same prices their third-party insurer pays — rates negotiated with provider networks. In addition, cash-paying patients often find physicians willing to provide discounts for services paid for at the time of delivery — allowing doctors to avoid the cost and delay of billing and collecting from insurers.²⁹

Conclusion

The concept of HSAs is not conservative or liberal. It’s an empowerment idea. It should appeal to liberals who want an alternative to HMO rationing. It should appeal to conservatives who want an alternative to government rationing. It should appeal to everyone who suspects that impersonal bureaucracies care less about us than we care about ourselves. Giving employees more choice and control over their health care makes good sense. It leads to lower costs and more control over the kinds of care they prefer.

¹ John C. Goodman, "Health Savings Accounts Will Revolutionize American Health Care," Brief Analysis No. 464, National Center for Policy Analysis, January 15, 2004.

² John C. Goodman, "Health Savings Accounts Will Revolutionize American Health Care," Brief Analysis No. 464, National Center for Policy Analysis, January 15, 2004.

³ Simon Rottenberg, "Unintended Consequences: The Probable Effects of Mandated Medical Insurance," *Regulation*, Vol. 13, No. 2 (Summer 1990), pp. 27-28.

⁴ Michael Walholz, "Genetic Testing Hits the Doctor's Office" *Wall Street Journal*, December 3, 2003.

⁵ The calculations are thus: the U.S. population of 288.4 million people multiplied by \$1.1 million per capita for the battery of tests. The resulting figure of \$317.2 trillion dollars is approximately 28.67 times the fourth quarter 2003 (annualized) gross domestic product of \$11 trillion.

⁶ For a brief analysis of the types of health accounts, see Michael F. Cannon, "Three Avenues to Patient Power," Brief Analysis No. 430, National Center for Policy Analysis, January 30, 2003.

⁷ For a brief analysis on flexible spending accounts, see Michael F. Cannon, "Flexible Spending Accounts: The Case for Reform," Brief Analysis No. 439, National Center for Policy Analysis, May 13.

⁸ Devon Herrick, "Health Reimbursement Arrangements: Making a Good Deal Better," National Center for Policy Analysis, Brief Analysis No. 438, National Center for Policy Analysis, May 8, 2003.

⁹ H.R. 4279. There was no corresponding Senate bill.

¹⁰ Regulations governing Health Reimbursement Arrangements (HRAs) were clarified by the IRS in June 2002 paving the way for large firms to begin considering them.

¹¹ Jon R. Gabel, Anthony T. Lo Sasso and Thomas Rice, "Consumer-Driven Health Plans: Are They More Than Talk Now?" *Health Affairs*, Web Exclusive, W407, November 20, 2002.

¹² Devon Herrick, "Health Reimbursement Arrangements: Making a Good Deal Better," Brief Analysis No. 438, National Center for Policy Analysis, May 8, 2003.

¹³ John C. Goodman, "Two Cheers for the Bush Health Plan," Brief Analysis No. 465, National Center for Policy Analysis, January 30, 2004.

¹⁴ This case study is based on Devon Herrick, "Why Are Health Costs Rising?" Brief Analysis No. 437, National Center for Policy Analysis, May 7, 2003.

¹⁵ Shaun Matisonn, "Medical Savings Accounts in South Africa," Policy Report No. 437, National Center for Policy Analysis, June 2000.

¹⁶ Shaun Matisonn, "Medical Savings Accounts and Prescription Drugs: Evidence from South Africa," Policy Report No. 254, National Center for Policy Analysis, August, 2002.

¹⁷ See Robin Downey (Aetna), presentation at Galen Institute Briefing "Consumer Choice Health Care: Reports from the Field" February 11, 2004; Aetna, "Aetna Research Shows Positive Impact of Consumerism on Health Care Decisions," Press Release, Aetna, February 16, 2004; and Michael Showalter (Definity Health), presentation at Galen Institute Briefing "Consumer Choice Health Care: Reports from the Field" February 11, 2004.

¹⁸ Michael F. Cannon, "Answering the Critics of Health Accounts," Brief Analysis No. 454, National Center for Policy Analysis, September 12, 2003.

¹⁹ Michael Showalter (Definity Health), presentation at Galen Institute Briefing "Consumer Choice Health Care: Reports from the Field" February 11, 2004.

²⁰ Stuart Slutzky (Destiny Health), "Debunking the Myths of Consumer-Driven Healthcare" presentation at Galen Institute Briefing, "Consumer Choice Health Care: Reports From the Field," February 11, 2004.

²¹ Robin Downey (Aetna), presentation at Galen Institute Briefing "Consumer Choice Health Care: Reports from the Field" February 11, 2004; Aetna, "Aetna Research Shows Positive Impact of Consumerism on Health Care Decisions," Press Release, Aetna, February 16, 2004

²² Stuart Slutzky (Destiny Health), "Debunking the Myths of Consumer-Driven Healthcare" presentation at Galen Institute Briefing, "Consumer Choice Health Care: Reports From the Field," February 11, 2004.

²³ For information about the RAND Health Insurance Experiment, see Robert Brook et al., *The Effect of Co-insurance on the Health of Adults* (Santa Monica, Calif.: Rand, 1984); and Willard Manning et al., "Health Insurance and the Demand for Health Care: Evidence from a Randomized Experiment," *American Economic Review*, June 1987. The Rand study was conducted from 1974 to 1982. A \$1,000 deductible over that period would be equivalent to a deductible between \$1,899 and \$3,718 today.

²⁴ Michael F. Cannon, "Answering the Critics of Health Accounts," Brief Analysis No. 454, National Center for Policy Analysis, September 12, 2003.

²⁵ Ibid.

²⁶ Robin Downey (Aetna), presentation at Galen Institute Briefing "Consumer Choice Health Care: Reports from the Field" February 11, 2004; and Aetna, "Aetna Research Shows Positive Impact of Consumerism on Health Care Decisions," Press Release, Aetna, February 16, 2004. Definity Health experienced similar results. See Michael Showalter (Definity Health), presentation at Galen Institute Briefing "Consumer Choice Health Care: Reports from the Field" February 11, 2004.

²⁷ Results from Definity Health. See Michael Showalter (Definity Health), presentation at Galen Institute Briefing "Consumer Choice Health Care: Reports from the Field" February 11, 2004.

²⁸ Stuart Slutzky (Destiny Health), "Debunking the Myths of Consumer-Driven Healthcare."

²⁹ Rebecca Cook, "Fed Up with Insurance, some Doctors want Payment in Cash," Associated Press, April 5, 2004.

The CHAIRMAN. Thank you very much, Dr. Goodman.
 Let me turn to Ron Williams, who is the president of Aetna. Welcome to the committee, Ron.

**STATEMENT OF RONALD A. WILLIAMS, PRESIDENT, AETNA,
 HARTFORD, CT**

Mr. WILLIAMS. Thank you, Chairman Craig and Senator Breaux. I am here to discuss Aetna's experience with consumer-directed health plans, including health reimbursement accounts and health savings accounts.

Aetna is one of the largest health insurers. We insure 13 million members, and we serve the very largest employers in America, as well as some of the smallest employers in America. We provide fully insured coverage and self insured. We provide coverage one million employer sponsored retirees and participate in the Medicare Advantage Program, serving over 100,000 retirees.

There are three major points I would like to make today. The first is that HRAs and HSAs are getting a very positive response from the marketplace. The second is Aetna has been committed to studying the impact on the consumer, and the data that we are seeing suggest that we are able to lower costs without compromising quality. The third point I will make will be some recommendations on the basis of feedback we are receiving from the marketplace.

This is a category that Aetna made a commitment to in July 2001 to launch health reimbursement accounts on the basis of early interpretations of Treasury Department guidance. I would say this is a product I have had personal experience with since I and my family have been enrolled in this plan since January 2002. It is something that Aetna has been deeply committed to and we have expanded our family of products, including stand-alone dental funds, pharmacy funds, and permitting consumers to take long term premium reimbursement as part of their health reimbursement account.

A few days ago we announced a new retiree reimbursement accounts designed to help employers contribute to employee accounts for qualified health expenses. The reason that we have committed to this is really listening to the voice of the market. When we have talked to employers, the cost of health care is something that they are very concerned about, and also as we talk to consumers, they have a strong desire to exercise much greater control over the health decisions and benefit dollars. Consumers want information on quality and cost. They want Web-based tools, and also they are interested in better understanding the value that their employers are providing in the form of health care. We believe the consumer-directed health plans encourage consumerism, and the market response reflects this.

Since September 2001 when we began to discuss our product, we have sold this product to over 190 employers, representing 180,000 members. Aetna's own employees are in this product, and our enrollment grew from less than 1 percent the first year we introduced it to over 75 percent 2 years later. We see employer adoption and early quote activity for the newly approved health savings accounts unfolding at a very rapid pace.

Since January 1, 2004, with the health savings account being approved, we have talked to more than 600 brokers and over 86 of our largest plan sponsor clients. So far we have actually sold 130 small employers into high deductible health plans that support HRAs, and we actually have sold four mid to large employers in HSAs, with one employer going so far as to reopen their open enrollment period to give the employees the option of participating in the health savings account.

We have conducted a study of 14,000 members on the basis of 9 months of data. This data is preliminary and we will be updating it shortly. We found that on the basis of looking at these 14,000 members in comparison to a matched cohort, who had been fully enrolled with Aetna for over 2 years, we saw a 1.5 percent increase in medical claims costs compared to double digit increases in a comparable population.

We had one employer who had an integrated Rx deductible and saw a significant decrease in Rx claim costs and increases in generic utilization. We also saw preventive visits increased. The age, the salary and the family status of people enrolled in the health reimbursement account was similar to the general population. We saw an increase in Web tools. Consumers were twice as likely, 9 out of 10 enrollees were satisfied or very satisfied with the product, and more satisfied based on the length of enrollment, and more than 50 percent carried balances forward.

Consumerism has had a very positive impact on health status and quality. All of the consumer-directed plans at Aetna sales provide first dollar coverage for routine physicals, well-baby visits, annual gynecological exams, and immunizations. We also provide health risk assessments to help the consumer be more aware.

In conclusion, Mr. Chairman, I believe there are important opportunities for improvement, and these would come in the areas of permitting consumers to make additional contributions for catch-up. The average retiree is likely to have to spend \$80,000 in excess of health care costs that Medicare would cover, and therefore the ability for catch-up would be important. We believe that increasing that amount that can be contributed at an earlier age would help, that pre-retirees would also be encouraged and permitted to participate to the extent that they continue working in the workforce and may still be eligible for Medicare. We believe that encouraging the Medicare program to look at consumer-driven health care arrangements would also be something we would be very interested in participating in.

Thank you for the opportunity to share our point of view.

[The prepared statement of Mr. Williams follows:]

TESTIMONY OF

**RONALD A. WILLIAMS
PRESIDENT
AETNA**

BEFORE THE

**SPECIAL COMMITTEE ON AGING OF THE
U.S. SENATE**

WEDNESDAY, MAY 19, 2004

**"HEALTH SAVINGS ACCOUNTS AND THE NEW MEDICARE
LAW: THE FACE OF HEALTH CARE'S FUTURE"**

Good afternoon, Mr. Chairman and members of the Committee. I am Ronald Williams, president of Aetna. I'm very pleased to be here today, and to describe to you Aetna's experience with consumer-directed plans, and in particular, HRAs and HSAs. As one of America's largest health insurers, Aetna is proud to serve 13.3 million health care consumers across America. Our customer base includes many of this country's largest employers, but we are equally privileged to serve mid-sized and small employers, individual insureds, more than one million retirees in employer-sponsored coverage and 100,000 retirees in Medicare Advantage plans.

A little more than two and a half years ago Aetna was the first national health insurer to offer a consumer-directed product which fully integrated health plans with Health Reimbursement Arrangements (HRAs). The Treasury's HRA regulations in the summer of 2002 allowed employers to restructure a portion of their benefit dollars into an account that their employees could direct against current health expenditures or accumulate against future health needs. The authorization of HSAs by Congress at the end of 2003 provided a critical extension of this concept, permitting employees to defer their own money into a similar, tax-advantaged health spending account that was also portable.

Within a year of its introduction, we expanded this family of plans, which we call Aetna HealthFund, to include two additional firsts, Aetna Dental Fund and Aetna Pharmacy Fund, products that introduced the HRA concept to specialty health coverage. On December 8, 2003, the day the Medicare Modernization Act was signed into law, we

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were again the first to announce that we would offer a new class of Aetna HealthFund plans incorporating Health Savings Accounts (HSAs). Earlier this week, Aetna announced the availability of Retirement Reimbursement Accounts (RRAs)¹, which allow employers to make regular contributions to employee accounts which will then be available to fund qualified health care expenses in retirement. Today, we offer consumer-directed product designs tailored to virtually all customer segments that we serve.

The decision to be a leader in this emerging world of consumer-choice plans required us to make a number of significant changes in our traditional business models, challenging some basic elements of conventional thinking in our industry. It also forced us to make substantial investments in information systems, product filings, online self-service tools and information resources, as well as other aspects of our business at a time when we were in a fundamental turnaround of our company. But the decision to pursue this course was a simple one.

Aetna was hearing from our customers the same messages that you were hearing from many of your constituents: that the tension between rising health care costs and the competitive business environment was becoming increasingly challenging. As a company with more than 27,000 employees, and more than 11,000 retirees with health benefits, we understood the issues these customers faced. While the perception exists that employers are rapidly shifting health benefit costs to consumers, in fact, consumers were shielded from actual costs for the last several decades. The consumer's share of

health care expenditures has declined from 44 percent in 1965 to 14 percent in 2001, and is now starting to increase as more employers are struggling to manage costs.²

Simultaneously, a potentially more significant development began to take place in the health benefits marketplace. Consumers, who have already revolutionized virtually every other aspect of the American economy, are demanding greater control over their health care decisions and their health benefit dollars. We are hearing this directly from our members, who increasingly are asking for information about both the cost and quality of health care. We see increased use of our health information web tools such as our member self-service website, Aetna Navigator, and our online physician directory, DocFind, as well as our 24-hour nurse hotline. Participating physicians also tell us about the value of informed and educated consumers in achieving improved health status.

Importantly, consumers continue to recognize the value of their employers' health coverage in providing financial protection and, in many instances, case or disease management support when confronted with a serious illness or injury. Employers, too, continue to see their role as critical in enhancing their employees' lives, well-being and ultimately, their productivity.

From efforts to reconcile all of these forces a new consumer-choice paradigm began to emerge, combining increased flexibility and financial accountability for individuals as health consumers with more traditional elements of health insurance protection when they are dealing with serious health events. Importantly, we believe that well-designed

consumer-directed plans should encourage consumerism in health care for people at various life stages. However, when consumers need expensive care, the traditional coverage available in these plans should also protect them.

The market response to consumer-directed plans in general, and now HSAs, has been dramatic. Since our first product offering in September 2001, 190 employers now provide Aetna consumer-directed plans to more than 180,000 members. In our own employee population, enrollment grew in these products over a two-year period from less than one percent to more than 75 percent. Adoption of these plans, either as an option to more traditional coverage or, increasingly, as an employer's only plan, continues to accelerate. And although the HSA legislation was enacted after the traditional sales season last year, our early quote activity suggests that adoption of these plans will continue to increase, supplementing rather than supplanting HRA plans in the market. Since January 2004, we have held meetings on HSAs with more than 600 brokers and customers, including a presentation to our Client Advisory Group, which represents 86 of our largest customers. In the small employer market, we have 130 HSA customers, and four in the mid- to large-employer market.

While we expected early interest in HSAs from small employers, many of whom were familiar with medical savings accounts (MSAs) and have non-calendar benefit years, two of our earliest HSA sales have been employers with approximately 2,000 eligible employees each, plus dependents. One of these employers took the unusual step of re-opening their plan year just to introduce the HSA option. It is also important to highlight

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that consumer-choice plans take many forms, and that by working closely with our customers, we have been able to tailor these products by customer need.

Aetna is committed to studying the impact of these types of plans on an ongoing basis. In February we announced the results of a study³ of approximately 14,000 individuals enrolled in Aetna HealthFund plans during the first nine months of 2003, comparing their claims activity to their same experience in other Aetna plans during the corresponding period in 2002 as well as that of a matched cohort enrolled in other plans. While the data is preliminary, results showed that Aetna HealthFund members had a 1.5 percent increase in medical claims, compared to double-digit increases for the comparable population. Results from one employer in the study that offered an integrated pharmacy benefit illustrated a decrease in pharmacy claim costs and a significant increase in generic utilization compared to the overall population. Importantly, the study found that the age and family status of members enrolled in consumer-directed plans was not significantly different than the general population.

The study confirmed significant increases in usage of Aetna's online health information and tools: members in Aetna HealthFund are twice as likely to use online tools as members in other types of plans. Importantly, 9 out of 10 enrollees in the plan said they were satisfied or very satisfied with the coverage, with satisfaction increasing the longer they were enrolled. Slightly over half of the members studied carried some fund balance over into the next year.

In order to continue to evaluate the impact and benefits of these plans, we expect to continue to study quality and cost indicators in these populations as well as those enrolled in our HSA-based plans and to publish the results.

The positive public policy implications of these new plan designs extend substantially beyond the obvious tax advantages to employees. The empowerment of consumers to engage more actively in their health and benefits decision-making should encourage greater individual awareness of health and health risks, increase communication between patients and doctors about treatment options and costs, and ultimately provide significant market incentives for the development of new treatments, technologies and delivery modalities designed to meet the needs of consumers. We have found that our own employee population has a better understanding of health expenditures as a result of knowing actual costs of their premium as well as out-of-pocket costs for health services.

Ultimately, we believe this engagement will also have a positive effect on both health status and quality of care, as consumers take more time to educate themselves about their unique health risks, preventive opportunities, the potential benefits and risks of their treatments, and the growing body of available data regarding optimal treatment protocols and outcomes-based measures of care quality. The importance of this issue was highlighted recently in a recent Institute of Medicine report on health literacy in America, which indicated that 90 million Americans have difficulty understanding and using health information, and that patients with low health literacy often forgo preventive treatment.⁴

Aetna is committed to providing simple, easy-to-use tools, services and credible health information to help our members make more informed decisions.

Another important component of Aetna's plans is 100 percent first dollar coverage of preventive care, such as routine physicals, well-baby visits, annual gynecologic exams and immunizations. Health Risk Assessments allow Aetna members to complete a simple, on-line questionnaire to determine health risks or disease states, and when financial incentives are used, more members are encouraged to take advantage of this opportunity. Aetna can then provide these members with relevant "pushed" health information, including reminders for mammograms, eye exams for diabetics, and more.

Of particular significance to this Committee is another public policy aspect of these consumer-directed plans, and that is their potential value to retirees. The number of Americans with access to employer-provided defined-benefit retiree coverage has declined while their share of the cost has increased significantly, driven by competitive cost pressures on employers, accounting requirements, and even basic employment patterns as employees change jobs more frequently in the course of their careers. At the same time, estimated costs of health care for retirees continue to rise dramatically notwithstanding increased funding for Medicare, as people live longer, drug and technology costs continue to rise, and sub acute health care assistance becomes a more common need of the elderly. HRAs and HSAs provide two new powerful and flexible vehicles that permit employees to carry benefit dollars – and in the case of HSAs, salary dollars – from periods of maximum earnings to post-employment periods of maximum

need. Recent estimates suggest that Americans may require a minimum of \$80,000, and in many cases substantially more, to meet post-retirement health care needs even with Medicare.⁵ HSAs and HRAs provide substantial tax assistance to consumers to help prepare for a more secure retirement.

For employers, the HRA provides a significant opportunity to continue some level of financial support for retirees. Contributions to a retirement HRA can be made by an employer regardless of the employee's other coverage, and can be continued even if the retiree becomes eligible for Medicare. Employers also have the flexibility to define vesting and use rules for HRA dollars. Indeed this may be one of the most enduring legacies of the HRA regulation.

The HSA legislation also provides a significant retirement funding opportunity through the permitted "catch-up" contributions after age 55. Unlike HRA dollars, these additional contributions can be made by the employees directly. Beginning in 2009 the permitted additional contributions will be \$1000 per year, meaning that an individual who works until Medicare eligibility can potentially save an additional \$10,000. We would support additional flexibility to add to these funds in anticipation of retirement, including increasing the amount that can be contributed, and allowing contributions to begin at an earlier age. For those employees who receive some form of lump sum payment at the termination of their employment, either as severance or as a partial pay-out of their pension, it would be a significant opportunity for them to defer a portion of the pay-out into their HSA.

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Many employees do not work to the age of Medicare eligibility, and we as a health benefits company are focused on providing affordable health solutions for this subset of retirees. HSA and HRA carry-forwards will make a substantial difference in the ability of these individuals to provide for their coverage needs in this pre-retirement period and to have greater control and peace of mind in planning for and selecting their retirement date. At the same time, there are an increasing number of workers who continue employment beyond age 65. These are often very valued workers who make a particularly meaningful contribution to their companies and to the American economy as a whole. Moreover, most of these workers continue coverage under their employer's active employee benefit plans and thus represent less or no burden on the Medicare system. We believe that if they otherwise meet the eligibility criteria to fund an HSA these individuals should be permitted to continue funding their accounts notwithstanding their eligibility for Medicare.

We would also welcome the opportunity to work with this Committee in developing consumer-directed options within the Medicare program itself. We could offer plan designs that are compatible with Medicare MSAs today, but we believe these plans would be more attractive if permitted CMS funding could be supplemented by the member or the health plan, and in higher amounts consistent with the HSA rules. This would allow improved continuity for members joining Medicare from private consumer-choice plans and allow them to retain their active consumer role in managing their health care and benefits.

Finally, as a leading provider of long-term care benefits, we applaud the inclusion of qualified long-term care premiums within the permitted expenditures of both HRAs and HSAs. This is important coverage for seniors, and an area where most Americans do not have sufficient coverage today. Because HSAs can be included in cafeteria plans, many employees will now have at least an indirect means of paying for this coverage through their flexible benefit plans. We have long advocated direct inclusion of qualified long term care as a permitted benefit in cafeteria plans, and we continue to believe that this would be very beneficial and effective public policy.

In conclusion, let me state that I appreciate the opportunity to meet with you this afternoon and to share our views and experiences related to health savings and health reimbursement accounts. I hope my brief remarks adequately convey the enthusiasm we feel about the potential for these important new funding arrangements to positively impact current health care costs and the long-term benefit needs of Americans. Our experience, and the experience of a growing number of employers, is that HSAs and HRAs represent an idea whose time has come in an increasingly consumer-centric era. We offer our support in working with you in your commendable efforts to encourage greater consumer choice and engagement in health care. We in the private sector will continue to build on the momentum you helped establish with new and innovative products and services.

¹ Aetna press release, May 17, 2004, www.Aetna.com

² CMS, Office of the Actuary, National Health Statistics Group

³ Aetna HealthFund study, Aetna press release, February 16, 2004, www.Aetna.com

⁴ Institute of Medicine, Health Literacy: A Prescription to End Confusion, April 8, 2004

⁵ Employee Benefits Research Institute

The CHAIRMAN. Mr. Williams, thank you very much.

Now let us turn to Robert Greenstein, as I said earlier, founder and executive director of the Center on Budget and Policy Priorities. Mr. Greenstein, welcome to the committee.

STATEMENT OF ROBERT GREENSTEIN, EXECUTIVE DIRECTOR, CENTER ON BUDGET AND POLICY PRIORITIES, WASHINGTON, DC

Mr. GREENSTEIN. Thank you, Mr. Chairman.

Today most employer based coverage is not high deductible coverage. In 2003 the average in-network deductible for employer based PPO plans was \$275 per individual. But with the advent of HSAs, this is very likely to change.

Workers in excellent health who do not expect to have high health care costs are likely to find HSAs very attractive, and this is particularly true of healthier workers who are affluent, since the value of the HSA tax breaks is worth the most to people in the highest tax brackets. Indeed, the HSA tax breaks have no income limit and therefore actually provide a way around the income limits that now apply to IRAs. Indeed, the tax shelter benefits are unprecedented anywhere in the tax code. Nowhere else in the tax code do you get a tax deduction for a deposit in an account, and then be able to make tax-free withdrawals from the same account.

But for less healthy individuals the story is quite different. If you are less healthy and you have lower moderate income, you often would be unable to afford the greater out-of-pocket costs associated with the high deductible plans. You would get little or no benefit from the tax breaks with HSAs because you are in a lower tax bracket, and you often would lack the resources or the income to make substantial contributions to the HSAs in the first place.

So the problem is one of adverse selection. The problem is that if healthy, affluent workers move to high deductible plans with HSAs and in substantial numbers, then less healthy, lower-income workers who want to remain in the comprehensive coverage are necessarily going to face rising premiums. As Senator Breaux rightly noted, three major studies from very distinguished institutions in the 1990's concluded that with these kinds of accounts, the risks of adverse selection were very high, and that if use of these accounts became widespread that premiums could more than double.

Now, some, such as Mr. Goodman, say these concerns are unfounded and that evidence shows that, but the evidence does not show that at all. He cited health reimbursement accounts that some employers have set up in the last few years. Those experiences are not directly applicable to HSAs because HRAs are fundamentally different than HSAs. Under the HRAs there were no tax deductible employee contributions allowed and no withdrawal for non-health expenses in retirement allowed. Take away those features and the calculus changes.

Similarly, the South Africa experience is wholly inapplicable for three reasons that I do not have time to go into in my 5 minutes now, but I will happy to discuss in the questions and answers.

The only real significant evidence we have from the MSA demonstration project is a GAO survey that found some evidence that adverse selection was occurring.

The concern too is that if employers begin to offer both comprehensive and HSA type high deductible plans and the healthier workers move into the high deductible plans, the premiums could rise so high for the more traditional comprehensive low deductible plans, that employers stop offering them. The Commonwealth Fund Study found that individuals aged 50 to 64 who purchased high deductible policies in the individual market similar to the plans required under HSAs were twice as likely as comparable individuals with low deductible employer based coverage to fail to see a doctor when a medical problem develops or to skip medical tests or follow-up treatment.

As Linda Blumberg of the Urban Institute recently warned, quote, "The practical effect of HSAs is that the most vulnerable populations are left bearing a greater burden of their health expenses." I would also like to comment for a minute on the proposal Secretary Snow talked about to add on top of the unprecedented tax breaks that already accompany HSAs, an additional deduction for the purchase of high deductible insurance in the individual market by people who have HSAs. Senator Breaux referred to a cost of \$16 billion. That is just for the HSA provisions in the Medicare law. Both Joint Tax Committee and the administration say the new deduction would cost \$25 billion over 10 years, bringing the total cost to \$41 billion over 10 years. That is nearly six times the \$6.4 billion official cost estimate you operated under for the HSA provisions of the Medicare Drug Bill at the time that the legislation was enacted last fall.

Making matters worse, one of the Nation's leading health care economists, Jonathan Gruber of MIT, recently analyzed the administration's deduction proposal and concluded that it would likely cause the ranks of the uninsured to increase by 350,000. Why would it cause the ranks of the uninsured to increase? Because the deduction would be of greatest benefit to high income taxpayers in the top brackets, and most of them are already insured. For people who do not earn enough to pay income tax or are in the 10 or 15 percent brackets, the deduction does not provide enough of a subsidy to make insurance affordable. Ninety percent of the uninsured are in the 0, 10 percent or 15 percent brackets.

At the same token, for an employer who is able to now say, look, my employees can go into the individual market, they can buy a high deductible plan and get a deduction for that, they can put money in an HSA and get a deduction for that, the likelihood is that some employers on the margin do not offer employer based coverage. Gruber's estimate is that the number of new people who would become insured as a result of the deduction, as Secretary Snow said, would be more than outweighed by the number who would lose coverage due to employer dropping. We would spend \$25 billion and increase the ranks of the uninsured.

The final point I would like to make is about the claim that HSAs would substantially lower health care costs. I think this claim is significantly overblown. A recent article by Henry Aaron of Brookings notes that most medical spending occurs during high cost episodes in which the total cost of care for patients greatly exceeds the limits of any high deductible, and that once you get be-

yond those limits, there is no greater constraint or incentive under these approaches.

Linda Blumberg of Urban Institute made the same point. She said because the vast majority of medical spending is attributable to a small share of individuals with very high medical expenses, the vast majority of medical spending will still occur with the higher deductibles.

There are two studies I am aware of here. In a RAND study, RAND projected—obviously it is not based on actual data because we do not have actual data with widespread use of HSAs yet, but RAND projected that under HSAs health spending would decline at most by 2 percent. A separate Urban Institute study projected that if the entire employer based system were switched to these kinds of accounts, there would be one-time savings only in the vicinity of 4 to 6 percent. To me that is not enough to justify \$41 billion in expenditure and the adverse selection that would result with significant injury to sicker and poorer workers.

Thank you.

[The prepared statement of Mr. Greenstein follows:]



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May 19, 2004

**Testimony of Robert Greenstein
 Executive Director, Center on Budget and Policy Priorities**

**Hearing on "Health Savings Accounts and the New Medicare Law:
 The Face of Health Care's Future?"**

before the Senate Special Committee on Aging

Mr. Chairman, Senator Breaux, and members of the Committee on Aging, I appreciate the invitation to testify today. I am Robert Greenstein, Executive Director of the Center on Budget and Policy Priorities, a non-profit policy institute that conducts research and analysis on fiscal policy and on programs and policies affecting low- and moderate-income families. The Center does not hold (and has never received) a grant or contract from any federal agency.

My written testimony focuses principally on three key issues related to Health Savings Accounts.

- The risk that widespread use of the recently enacted Health Savings Accounts (HSAs) will significantly weaken the comprehensive employer-based health insurance system through which the vast majority of Americans now obtain their health insurance. Because HSAs will be most attractive to healthy and more affluent workers, HSAs are likely over time to result in "adverse selection" — that is, in the separation of healthy and less-healthy workers into different insurance arrangements, with healthier workers shifting to HSAs and high-deductible policies and older and sicker workers seeking to remain in comprehensive insurance. This development may make the comprehensive health insurance coverage that employers now typically offer increasingly unaffordable over time for vulnerable older and sicker workers who need such coverage and seek to remain in it.
- The likelihood that the Administration's fiscal year 2005 budget proposal to provide a tax deduction for the premium costs of high-deductible health insurance purchased in the individual market in conjunction with HSAs would primarily benefit higher-income individuals who already are insured, and would *increase* the number of Americans without insurance because it would increase incentives for employers not to offer coverage. This proposal also would have a detrimental impact on both federal and state budgets.
- The danger that HSAs would serve as a damaging precedent for enactment of additional tax proposals that would aggravate an already bleak long-term federal fiscal outlook. HSAs breached the long-standing rule of the tax code that savings accounts may not feature *both* tax-deductible contributions *and* tax-free

withdrawals. Extending the type of “double-dip” tax benefits that HSAs offer into retirement accounts would make the long-term deficit picture markedly worse than it already is.

Brief Overview of the Health Savings Accounts Provisions in the Medicare Law

Health Savings Accounts were established as part of last year’s Medicare drug legislation.¹ Under that law, any individual who enrolls in a high-deductible health insurance plan with a deductible of at least \$1,000 for individuals and \$2,000 for family coverage may establish a tax-favored savings account known as a Health Savings Account.² An individual with a HSA may take a tax deduction for contributions to the account equal to 100 percent of the health insurance deductible so long as the contributions do not exceed an annual limit, which is set at \$2,600 for individuals and \$5,150 for family coverage in tax year 2004.³ Both employers and employees may make deductible contributions to HSAs in the same year; the aggregate contributions are subject to the contribution limit.

Funds held in these accounts may be placed in various investment vehicles such as stocks and bonds, with earnings accruing on a tax-free basis. Withdrawals from the account also are exempt from tax if they are used to pay for out-of-pocket medical costs such as deductibles, co-payments, and other uncovered medical expenses. Withdrawals for non-medical purposes are subject to income tax and a financial penalty, but no penalty applies to non-medical withdrawals made after reaching age 65.⁴

HSAs Pose Substantial “Adverse Selection” Risk to Comprehensive Employer-Based Health Insurance

Health Savings Accounts pose a significant risk of weakening the existing comprehensive employer-based health insurance market due to what economists and health analysts call “adverse selection,” under which healthier, low-risk individual abandon one type of health insurance for another. When this occurs, the people who remain in the initial type of insurance constitute a group that becomes less healthy, on average, and hence more expensive to insure, which pushes up premiums for that type of coverage. The rise in premiums then induces still more of the healthier individuals to abandon that form of insurance. Over time, a so-called

¹ For an analysis of Health Savings Accounts generally, see Robert Greenstein and Edwin Park, “Health Savings Accounts in Final Medicare Conference Agreement Pose Threats Both to Long-Term Fiscal Policy and to the Employer-Based Health Insurance System,” Center on Budget and Policy Priorities, revised December 1, 2003.

² In addition, the high-deductible health insurance plan must have an out-of-pocket limit of no more than \$5,000 for individuals and \$10,000 for family coverage. Certain preventive services such as annual physicals and routine screenings may be exempted from the deductible.

³ Individuals age 55 or older may make additional contributions (in excess of the annual limit) of up to \$500 in tax year 2004, rising to \$1,000 by tax year 2009. Individuals age 65 or older are no longer eligible to make deductible contributions to HSAs.

⁴ The financial penalty for a non-medical withdrawal prior to retirement age of 65 is equal to 10 percent. Unlike other retirement accounts, there are no mandatory withdrawals upon retirement.

“death spiral” can result, whereby healthy individuals abandon such coverage in mounting numbers, causing premiums to climb to levels that are unaffordable.⁵ As discussed in greater detail below, due to the advent of HSAs, adverse selection is likely to occur as healthy individuals abandon comprehensive employer-based plans for high-deductible plans used in conjunction with HSAs.

Today, the employer-based health insurance system typically offers comprehensive health insurance coverage. Such coverage generally carries relatively modest deductibles and co-payment charges and covers a wide array of benefits. It may be provided through a variety of administrative structures including HMOs, Preferred Provider Organizations (PPOs), and Point-of-Service (POS) plans. (These are also the types of plans through which many members of Congress and their staffs obtain coverage, such as through the Blue-Cross-Blue-Shield Standard Option offered under the Federal Employee Health Benefits Program.)

Rapidly increasing health care costs and the current economic slump have encouraged some employers to increase the deductibles and co-payments that workers must shoulder and have somewhat reduced the scope of benefits.⁶ Nevertheless, high-deductible plans are still far from the norm in employer-based coverage. For example, among PPO plans in 2003, the average in-network deductible was \$275 per individual, well below the minimum \$1,000 deductible for individuals required under HSAs.⁷ As a result, according to the Joint Committee on Taxation, only a “very small number” of employers currently offer high-deductible plans meeting the statutory requirements of HSAs.⁸

With the advent of HSAs, however, many healthy workers are likely to find high-deductible plans considerably more attractive. Because of their excellent health, these workers would believe they will not require much health care and therefore will not need the greater financial protection that comprehensive coverage provides. Moreover, if they end up using little or no health care, healthy workers can accumulate funds in their HSAs on a tax-advantaged basis since earnings accrue tax-free in these accounts. In addition, as noted above, any funds that individuals deposit in HSAs are tax-deductible.

⁵ An example of how adverse selection can occur in nature involves the Blue Cross-Blue Shield “high option” for federal employees, which had a somewhat lower deductible than the “standard option” and a slightly higher premium. Young and healthy employees ended up primarily choosing the standard option because they believed they could bear the risk of the higher deductible due to their health status and would rather pay a lower premium. Older and sicker employees, on the other hand, who preferred more comprehensive coverage because of their need for substantial health care services, participated in the high option. Over time, the premiums for the high option increased substantially due to the concentration of older and sicker workers in the high option. When last offered in 2001, the high option family coverage premium was \$1,500 higher than the family coverage premium for the standard option. As a result, the high option was dropped from the Federal Employees Health Benefits Program. Leonard Burman and Linda Blumberg, “HSAs Won’t Cure Medicare’s Ills,” Urban Institute, November 21, 2003.

⁶ Sara R. Collins, Cathy Schoen, Michelle M. Doty and Alyssa L. Holmgren, “Job-Based Health Insurance in the Balance: Employer Views of Coverage in the Workplace,” The Commonwealth Fund, March 2004.

⁷ Kaiser Family Foundation and Health Research and Educational Trust, “Employer Health Benefits: 2003 Annual Survey,” 2003.

⁸ Letter from George K. Yin, Joint Committee on Taxation, to the Honorable Charles B. Rangel, November 21, 2003.

Healthy people who are affluent can find this particularly advantageous; higher-income workers can better afford the risk of high-deductible coverage if they do become sick, and they also secure the largest tax deductions for deposits into HSAs. That is because the value of a tax deduction rises with an individual's tax bracket. In addition, these workers' employers would be able to make deposits into their HSAs on their behalf. (Firms receive the full employer health-insurance deduction for such deposits.) Moreover, withdrawals from the accounts used for out-of-pocket medical costs are tax-free. Finally, unlike traditional Individual Retirement Accounts (IRAs), there are no income limits on who can participate in HSAs. As a result, these accounts can be quite lucrative as tax shelters for healthy and affluent individuals.

A recent survey of nearly 1,000 employers conducted by Mercer Human Resource Consulting appears to confirm the attractiveness of HSAs to healthy, higher-income workers. The survey found that a large majority of employers (61 percent) believed their *higher-paid* employees would be most likely to participate in HSAs. A plurality (44 percent) believed that their *healthiest* employees would be most likely to participate.⁹ Similarly, evidence from a General Accounting Office survey of insurers that was conducted in conjunction with the Medical Savings Account demonstration project, which preceded HSAs and included fewer tax benefits, found that "insurers expect relatively better health status and lower service utilization by enrollees selecting high deductible plans."¹⁰

Older and sicker workers, on the other hand, would prefer to remain in the comprehensive coverage typically offered by employers today.¹¹ Early retirees would be one population that would tend to choose to remain in comprehensive coverage. A Commonwealth Fund study found that 26 percent of all adults ages 62-64 are in fair or poor health and require more health care services on average.¹² Older and sicker workers who have low incomes are particularly likely to prefer comprehensive plans, as they often would be unable to afford the greater out-of-pocket costs required under high-deductible plans. Moreover, low-income individuals derive little or no benefit from the tax benefits of HSAs, and they generally lack the income or resources to make substantial contributions to HSAs.

⁹ Mercer Human Resource Consulting, "US Employers See a Role for New Health Savings Accounts in their Benefit Programs," April 26, 2004.

¹⁰ General Accounting Office, *Medical Savings Accounts: Results from Surveys of Insurers*, December 31, 1998, GAO/HEHS-99-34, Appendix.

¹¹ Some proponents of HSAs dispute this notion. They argue that sicker individuals would prefer high-deductible plans because it provides protection against catastrophic costs once the deductible is exceeded. This, however, is quite unlikely to be the case. There is no requirement that high-deductible plans related to HSAs provide 100 percent coverage for health care costs in excess of the deductible. The only requirement is that such plans have an overall out-of-pocket limit of no more than \$5,000 for individuals and \$10,000 for family coverage. Such limits are well above the out-of-pocket limits currently found in traditional comprehensive employer-based coverage. Not only do traditional comprehensive employer-based plans generally require significantly lower deductibles, but among all PPO plans in 2002 (the last year for which such data are available), 79 percent set a maximum out-of-pocket limit of \$3,000 or less. Kaiser Family Foundation and Health Research and Educational Trust, "Employer Health Benefits: 2002 Annual Survey," 2002.

¹² John Sheils and Ying-Jun Chen, "Medicare Buy-In Options: Estimating Coverage and Costs," The Commonwealth Fund, February 2001.

Would Widespread Use of HSAs Reduce Overall Health Care Costs?

Proponents of HSAs argue that high-deductible policies would discourage unnecessary utilization of health care services by requiring individuals to bear a greater portion of the costs of their care. As a result, supporters argue HSAs would produce substantial reductions in overall health care spending in the United States over time.

It is unlikely, however, that HSAs would provide significant cost containment. According to recent research, 10 percent of the population accounts for 69 percent of total health care spending, and as Henry Aaron, a Senior Fellow at the Brookings Institution and a leading expert in the areas of health care and tax policy, explains in a recent *Tax Notes* article: "...most medical spending occurs during high-cost episodes in which the total cost of care charged to patients greatly exceeds the limits of any plausible high-deductible plan....Once patients enter the stop-loss range of their insurance, they would, by definition, be as free of financial discipline to attend to health care costs as they are under low-deductible insurance. The direct effects of high-deductible insurance on health care costs are therefore likely to be small." Similarly, Linda Blumberg, a Senior Research Associate at the Urban Institute, has concluded: "Because the majority of spending is attributable to the small share of individuals with very large medical expenses, increasing deductibles even to \$1,000 or \$2,000 from currently typical levels will not decrease premiums dollar for dollar. The vast majority of medical spending still will occur above even these higher deductibles."

It also should be noted that research indicates that increased cost-sharing requirements are a blunt instrument with which to try to control costs. Among low-income individuals, higher cost-sharing charges can discourage utilization of *both* necessary and unnecessary services. If a medical condition or illness goes untreated because individuals are unable to pay for appropriate care out-of-pocket, this can eventually lead to greater use of more expensive services like hospitalization. For some individuals, the high-deductible insurance policies required under HSAs thus might actually result in increases in health care costs over time.

* Karen Davis, Testimony before the U.S. Senate Committee on Health, Education, Labor and Pensions, January 28, 2004 citing A.C. Monheit, "Persistence in Health Expenditures in the Short-Run: Prevalence and Consequences," *Medical Care* 41, supplement 7:1153-1164, 2003; Henry Aaron, "HSAs — The 'Sleeper' in the Drug Bill," *Tax Notes*, February 23, 2004; Linda J. Blumberg, Testimony before the Subcommittee on Workforce, Empowerment and Government Programs, U.S. House Committee on Small Business, March 18, 2004; and see also Jon R. Gabel, Heidi Whitmore, Thomas Rice and Anthony T. LoSasso, "Employers' Contradictory Views about Consumer-Driven Health Care: Results from a National Survey," *Health Affairs* (Web Exclusive), April 21, 2004.

With healthy, affluent workers moving to high-deductible plans in conjunction with HSAs while older and sicker workers remain in comprehensive coverage, premiums for comprehensive plans would necessarily rise. Research conducted in the mid-1990s on the likely effects of Medical Savings Accounts by RAND, the Urban Institute, and the American Academy of Actuaries concluded that the risks of adverse selection were quite high and that premiums for comprehensive insurance could more than double if MSA use becomes widespread.¹³

¹³ Emmett B. Keeler, et. al., "Can Medical Savings Accounts for the Nonelderly Reduce Health Care Costs?" *Journal of the American Medical Association*, June 5, 1996, p. 1666-71; Len M. Nichols, et. al., "Tax-Preferred Medical Savings Accounts and Catastrophic Health Insurance Plans: A Numerical Analysis of Winners and Losers," *The Urban Institute*, April 1996; and American Academy of Actuaries, "Medical Savings Accounts: Cost Implications and Design Issues," May 1995.

In the past, some have downplayed the risks of adverse selection on the grounds that HSAs are unlikely to proliferate in the employer-based health insurance market. It is increasingly clear that such a judgment is mistaken. To provide benefits that are attractive to their managers, firms generally must provide low-cost, comprehensive coverage to all of their workers. With HSAs, however, employers can provide less costly, less generous high-deductible plans tied to HSAs without worrying as much that such plans might encourage executives to seek jobs elsewhere that offer better health benefits. High-income managers and executives could use their HSAs as tax shelters by making substantial contributions to the HSAs on a tax-deductible basis. Since these individuals would have the ability to accumulate significant amounts in their HSAs — and the value of the HSA tax break is greatest for those in the top tax brackets — these tax benefits could more than make up for the increases in deductibles and other reductions in covered benefits that the executives could face under the high-deductible plans their employers might substitute for more comprehensive coverage. With health insurance premium costs rising annually at double-digit rates in recent years, this could make HSAs particularly attractive to employers.

For rank-and-file lower-income workers, however — and especially for older, less healthy workers — such a change would generally be harmful. Those workers would lose the comprehensive low-deductible insurance that they need and receive in its place a tax break of little value to them.¹⁴

In providing a cost estimate to accompany the Medicare prescription drug bill, the Joint Committee on Taxation assumed that HSA would expand significantly, starting at one million participants in tax year 2004 and rising to three million by 2013. (By comparison, in tax year 2001, the most recent year for which IRS data are available, fewer than 80,000 people participated in the Medical Savings Account demonstration project).

But most analysts now believe the JCT estimate dramatically understates likely HSA use, given the widespread attention that HSAs are receiving and the intention of various insurance and financial investment companies to offer HSAs and high-deductible policies and market them heavily. The Administration now estimates that the HSA provisions of the new Medicare law will cost \$16 billion over ten years, two-and-a-half times the \$6.4 billion that Congress assumed when the law was enacted. In addition, the employer survey discussed above found that nearly three-quarters of employers (73 percent) are likely or somewhat likely to offer Health Savings Accounts by 2006. A smaller employer survey conducted by Hewitt Associates found that 61 percent of employers are likely to offer HSAs in the near future.¹⁵

¹⁴ Some proponents of HSAs may argue that employers will hold workers harmless — that the increase in the deductible will be offset by an employer contribution to the HSA equal to the difference between the current deductible required under a comprehensive plan and the one required under the high-deductible health insurance plan provided in conjunction with the HSA. To the degree that employers are looking at HSAs as a lower-cost health insurance alternative, however, this does not appear likely. In the Mercer employer survey, 77 percent of employers expected their HSA contribution amounts to be lower than the deductible amount in the high-deductible plan that they would offer in connection with HSAs, and a plurality of employers (39 percent) expected they would not make any contribution at all to workers' HSAs. Mercer Human Resource Consulting, *op cit*.

¹⁵ Hewitt Associates, "Addition of HSAs Will Require Substantial Health Plan Design Changes," March 31, 2004.

If HSA use becomes widespread, as is likely, and premiums for the comprehensive coverage typically offered by employers today rise substantially (with some employers dropping comprehensive coverage entirely), many older and sicker workers, including early retirees, would suffer adverse consequences. Such individuals would either have to switch to a high-deductible plan or become uninsured.

Coverage through high-deductible plans would leave many such individuals underinsured; such plans are likely to provide inadequate coverage for these workers. A Commonwealth Fund study reported that older individuals ages 50-64 who have purchased high-deductible policies in the individual market similar to the plans required under HSAs are twice as likely as comparable individuals with comprehensive employer-based coverage to fail to see a doctor when a medical problem develops or to skip medical tests or follow-up treatment.¹⁶ Another Commonwealth analysis determined that so-called “bare-bone” health plans — which may be comparable to some of the high-deductible plans provided with HSAs — can leave some lower-wage individuals and families with catastrophic costs well in excess of their annual incomes.¹⁷

A study conducted by the Center for Studying Health System Change estimated that high-deductible, less comprehensive plans would expose many individuals to substantial out-of-pocket costs; nearly a third of individuals in poor health enrolled in hypothetical plans with high deductibles of \$1,000 were projected to incur out-of-pocket costs in excess of 10 percent of their annual incomes. The study also estimated that more than half of such individuals would incur out-of-pocket costs of this magnitude if they were enrolled in hypothetical plans with deductibles of \$2,500.¹⁸

As Linda Blumberg of the Urban Institute recently warned, “the practical effect [of HSAs]...is that the most vulnerable populations (the sick and low-income) are left bearing a greater burden of their health expenses.”¹⁹ Such individuals will either have to spend more out-of-pocket or go without essential health care services they may need. A study from the Employee Benefit Research Institute concludes that the loss of comprehensive coverage generally would leave many people who need significant amounts of health care, such as individuals with chronic conditions, little recourse but to become underinsured or uninsured.²⁰

¹⁶ Elisabeth Simantov, Cathy Schoen and Stephanie Bruegman, “Market Failure? Individual Insurance Markets for Older Americans,” *Health Affairs*, July/August 2001.

¹⁷ Shery Glied, Cathi Callahan, James Mays and Jennifer Edwards, “Bare-Bones Health Plans: Are They Worth the Money?,” *The Commonwealth Fund*, May 2002.

¹⁸ Sally Trude, “Patient Cost-Sharing: How Much Is Too Much?,” *Center for Studying Health System Change*, December 2003.

¹⁹ Linda J. Blumberg, Testimony before the Subcommittee on Workforce, Empowerment and Government Programs, U.S. House Committee on Small Business, March 18, 2004.

²⁰ Laura Tollen and Robert Crane, “A Temporary Fix? Implications of the Move Away from Comprehensive Health Benefits,” *Employee Benefit Research Institute*, April 2002.

Proposed Deduction for the Premium Cost of High-Deductible Health Insurance Purchased in the Individual Market Would Worsen Problem of Uninsured

At a cost of \$25 billion over ten years, the Administration's fiscal year 2005 budget proposes to further expand enrollment in Health Savings Accounts by allowing HSA participants to claim a tax deduction for the premium costs of high-deductible health insurance policies they purchase in the individual health insurance market.²¹ (The deduction would not be available to HSA participants who obtain high-deductible coverage through their employer.) The deduction would be available without regard to whether an individual itemizes deductions.

M.I.T. economist Jonathan Gruber, one of the nation's leading health economists, has analyzed the proposal, using his highly regarded health insurance model. Gruber's analysis finds that because of the adverse effects it would have on employer-based coverage, this deduction would likely cause the ranks of the uninsured to *increase* by 350,000.

The value of a tax deduction rises with an individual's tax bracket. The proposed deduction consequently would be of greatest benefit to high-income taxpayers, who would receive the largest tax benefits from the deduction because they are in the highest tax brackets. The vast bulk of people in the higher tax brackets who would use the deduction, however, will have health insurance *regardless* of whether the deduction is established.

At the other end of the income spectrum, workers who do not earn enough to owe income tax would receive no benefit whatsoever from the deduction. In addition, for moderate- and middle-income taxpayers in the 10 percent or 15 percent tax brackets, the deduction would reduce the cost of health insurance policies by only 10 percent or 15 percent, too little in most cases to make health insurance affordable. This is significant because about three-quarters of all U.S. households — and something like 90 percent of the uninsured — are either in the 10 percent or 15 percent tax bracket or earn too little to owe income tax.²² As a result, the deduction would have only small effects in helping the uninsured purchase high-deductible health insurance policies in the individual market.

The deduction thus poses a problem: it would not do much to help people who cannot afford insurance to secure it. Yet the availability of HSAs and the deduction would encourage some employers to drop employer-based coverage (or not to offer it in the first place), since their workers could now receive tax preferences if they use HSAs and purchase high-deductible policies on their own. In research conducted for the Kaiser Family Foundation, Professor Gruber examined the coverage effects of the proposed deduction. He found that the number of workers who would lose coverage because of actions by their employers to drop coverage (or to decrease

²¹ Currently, funds held in HSAs may not be generally used to pay the premium costs of health insurance. There are limited exceptions to the rule that tax-free withdrawals from HSAs may not be used to pay premiums for health insurance. Tax-free withdrawals from HSAs may be used to pay for health insurance premiums under COBRA or while an individual is unemployed, for long-term care insurance premiums, or for premiums for private supplemental coverage under Medicare.

²² In an analysis issued in 1998, the General Accounting Office found that more than 90 percent of the uninsured had no tax liability or were in the 15 percent tax bracket. General Accounting Office, Letter to the Honorable Daniel Patrick Moynihan, June 10, 1998. The 10 percent tax bracket, which was carved out of the 15 percent bracket by the 2001 tax legislation, did not yet exist.

employer contributions toward health insurance premiums) would likely *exceed* the number of uninsured individuals who would gain coverage as a result of the deduction.

Specifically, Professor Gruber, who is highly regarded in the economics profession for the rigor of his work on health care and other matters, projects that nearly eight million people would use the proposed tax deduction.²³ But he also projects that only about 1.1 million of these participants — or 13 percent of them — would previously have been uninsured. Nearly 87 percent of those who would use the deduction would already have health insurance (of whom the overwhelming majority would have coverage they purchased through the individual market) and would essentially be obtaining a tax break for insurance they already can afford (see Table 1).

Gruber also finds that the deduction would prompt some employers to drop existing employer-sponsored coverage or, in the case of new employers, to elect not to offer it. The combination of HSAs and the availability of the new tax deduction to workers who obtain health insurance in the individual market — rather than through their employer — would almost certainly be regarded by some employers as lessening the need for them to offer coverage. Professor Gruber estimates that employers currently covering 2.1 million workers would drop coverage. He estimates that 1.2 million of these workers — a little more than half of them — would become uninsured.

Some employers would be expected to retain coverage but to scale back their contributions to the premium costs of coverage, on the grounds that the new deduction lessens the need for as significant an employer contribution. Gruber finds that a modest number of workers whose employers would reduce employer contributions — 190,000 such workers — would drop out of employer-based coverage and become uninsured. This brings to 1.4 million

Table 1
Projected Effects of Fiscal Year 2005
Administration HSA Deduction Proposal
in Reducing the Number of Uninsured

Projected number of total participants in the tax deduction	7.98 million
Number of participants who would previously have had health insurance coverage	6.91 million (86.6%)
Number who would previously have been uninsured and would gain coverage	1.07 million (13.4%)
Number who would previously have had employer-based coverage but would become uninsured as their employers dropped coverage or reduced their premium contributions.	-1.41 million
Net effect on number of individuals with health insurance coverage	-350,000
* Analysis by Professor Jonathan Gruber, March 12, 2004. Numbers may not add due to rounding.	

²³ Communication with Professor Jonathan Gruber, March 12, 2004. See also Kaiser Family Foundation, "Coverage and Cost Impacts of the President's Health Insurance Tax Credit and Tax Deduction Proposals," March 2004. The analysis that Professor Gruber conducted for the Kaiser Family Foundation report determined the simultaneous coverage effects of both the deduction and the Administration's proposal to provide a refundable tax credit for the purchase of health insurance in the individual market. The analysis cited here and communicated to CBPP shows the effects of the deduction separately.

the total number of people who would lose coverage and become uninsured as a consequence of employer actions taken in response to the establishment of deduction.

With about 1.1 million uninsured people gaining coverage as a result of the deduction and about 1.4 million losing coverage, Gruber's analysis finds that the likely net effect of the deduction would be to increase the number of uninsured individuals by approximately 350,000 (see Table 1).

The deduction also would affect the budget. Unless its costs were fully offset, the proposal would increase federal deficits. As noted, the Administration now expects the HSA provisions enacted as part of the Medicare prescription drug legislation to cost two-and-a-half times as much as the Joint Committee on Taxation estimated when the Medicare legislation was enacted. Many experts share the Administration's view that the Joint Tax Committee's estimate of the cost of the HSA provisions, upon which Congress relied when enacting the Medicare legislation, is too low. HSA use now is expected to be significantly more widespread than the Joint Committee on Taxation assumed when it developed the cost estimate for the HSA part of the Medicare bill.

The proposed deduction would cause use of HSAs to become still more widespread, further intensifying the risks of adverse selection, because the deduction would substantially enhance the already-generous tax benefits that HSAs offer, especially to individuals in the higher tax brackets. This is part of the reason that the proposed deduction carries a \$25-billion price tag.

The Administration projects that the combined cost of the HSA provisions in the Medicare drug legislation and the new deduction would be nearly \$41 billion over ten years. To put this figure in perspective, when Congress passed the Medicare bill, it thought the cost of the bill's HSA provisions would be \$6.4 billion over ten years, based on the Joint Tax Committee estimate — less than one-sixth as much.

The proposed deduction also would place some strain on state budgets. State income tax codes generally conform to the definition of taxable income in the federal income tax code. Many states consequently would experience revenue losses if the proposed deduction became law.

HSAs Also Constitute Dangerous Precedent for Long-Term Fiscal Policy

Under the tax code, a basic principle governs: If contributions to a savings or retirement account are tax deductible and earnings on the account compound tax-free, then withdrawals from the account are taxed as ordinary income. This is how 401(k)s, traditional IRAs, and similar accounts long have worked. (There are several types of accounts from which withdrawals are tax-free, but contributions to those accounts are *not* tax deductible.)

Under Health Savings Accounts, this fundamental principle is abrogated. Not only are deposits to HSAs tax deductible, with earnings then compounding on a tax-free basis, but *withdrawals also are tax free* so long as they are used for medical costs. Allowing an account to feature *both* tax-deductible contributions *and* tax-free withdrawals is unprecedented. (Note:

This was a feature of Medical Savings Accounts which preceded HSAs, but MSAs operated only as a demonstration project on a very limited basis and were not available to most people. Unlike MSAs, HSAs are universally available and provide more extensive benefits as a tax shelter.)

The Congressional Budget Office projects that the federal government will collect several trillion dollars in revenue over the course of future decades as tens of millions of Americans retire and withdraw funds from 401(k)s and IRAs. These anticipated revenues are reflected in the long-term budget baseline. Even with these revenues, the long-term fiscal picture is bleak; budget deficits are expected to rise eventually to levels dangerous to the economy. Stern warnings about the fiscal dangers that lie ahead have been voiced recently by the International Monetary Fund, the Comptroller General of the United States (the head of the General Accounting Office), the Chairman of the Federal Reserve, the investment house Goldman Sachs, and such luminaries as former Treasury Secretary Robert Rubin, former Senator Warren Rudman, and former Congressional Budget Office director Robert Reischauer.

For example, the *New York Times* reported that an IMF report issued in January “sounded a loud alarm about the shaky fiscal foundation of the United States...warning that large budget deficits pose ‘significant risks’ not just for the United States but for the rest of the world.”²⁴ In strong language usually reserved for developing countries struggling with international debt obligations, the IMF report disapprovingly noted that the “United States is on course to increase its next external liabilities to around 40 percent of GDP within the next few years — an unprecedented level of external debt for a large industrial country.”²⁵

If the precedent that HSAs set is pursued — and policymakers begin allowing some of the funds deposited in retirement accounts into which contributions were made on a tax-deductible basis to be withdrawn tax free, so long as they are used for health care or some other designated purpose — an already grim long-term fiscal outlook will become considerably worse. In a recent scholarly assessment of the nation’s long-term fiscal problems, Alan Auerbach of the University of California at Berkeley, one of the nation’s leading public finance experts, and Brookings economists William Gale and Peter Orszag warn that “...proposals to reduce the taxation of withdrawals from retirement accounts could significantly and adversely affect an already bleak fiscal outlook.”²⁶

Indeed, financial services industry lobbyists have already begun promoting the idea of letting workers designate a portion of their 401(k)s and IRAs as “Retirement Medical Benefit Accounts” (or RMBAs), from which funds deposited on a deductible basis could be withdrawn in retirement on a tax-free basis for out-of-pocket medical costs.²⁷ Such a step would result in

²⁴ Elizabeth Becker and Edmund Andrews, “I.M.F. Warns that U.S. Debt is Threatening Global Stability,” *The New York Times*, January 8, 2004.

²⁵ International Monetary Fund, “U.S. Fiscal Policies and Priorities for Long-Run Sustainability,” IMF Occasional Paper 227, January 7, 2004.

²⁶ Alan J. Auerbach, William G. Gale, and Peter R. Orszag, “Reassessing the Fiscal Gap: The Role of Tax-Deferred Savings,” *Tax Notes*, July 28, 2003.

²⁷ For an analysis of the RMBA proposal, see Edwin Park and Robert Greenstein, “New Retirement Medical Account Proposal Would Create Lucrative Tax Shelter and Swell Deficits, But Do Little to Help Low- and Moderate-Income Seniors with Health Care Costs.”

large revenue losses over time, materially worsening the nation's long-term fiscal position. Such a proposal also could open the floodgates for proposals to allow steadily increasing shares of 401(k) and IRA assets to be set aside for favored purposes and then withdrawn tax-free for those purposes in retirement. If that occurs, the long-term fiscal consequences could be profound. As with the proposed premium deduction for HSAs, RMBAs also would place a strain on state budgets.

Over time, the RMBA proposal also could result in adverse effects on non-affluent Medicare beneficiaries. The large long-term revenue losses that the proposal would engender could intensify budgetary pressures to cut Medicare and other programs down the road.

Furthermore, the existence of RMBAs could facilitate the emergence of proposals to increase Medicare premiums, deductibles, and other cost-sharing charges quite substantially over time. The RMBA proposal may be marketed now partly as a way to help future Medicare beneficiaries pay for Medicare premiums, deductibles, and cost-sharing. But in the future, when the long-term effects of the tax cuts in shrinking the nation's revenue base collide with the mounting costs for retirement and health care programs for the elderly, RMBAs could be used to advance controversial proposals to reduce Medicare services markedly or increase substantially the charges that Medicare beneficiaries must pay. The argument would be that Medicare beneficiaries could absorb increased charges and decreased coverage in Medicare because they could draw funds tax free from RMBAs to help defray such costs.

That may be true for high-income beneficiaries. But RMBAs are likely to be of little help to most low- and moderate-income people; they would primarily be a windfall for the more well-off. Since high-income households are in the highest tax brackets, they would secure the largest tax deductions for contributions to these accounts, and they also would garner the largest tax benefits from being able to withdraw funds from the accounts on a tax-free basis. In addition, high-income individuals are the people who could most afford to make large deposits into such accounts.

But data on participation in, and contributions to, IRA and 401(k) accounts show the majority of low- or moderate-income households do not even have such accounts. A combination of RMBAs and increases in Medicare beneficiary charges would likely have a net positive effect on the pocketbooks of high-income Medicare beneficiaries but a decidedly negative effect on senior citizens of modest means.

Conclusion

Use of Health Savings Accounts is likely to become more widespread over time. Such a trend is likely to create a troubling system of winners and losers in the U.S. health care system. Individuals who are healthy and affluent would gain from the tax benefits that HSAs offer. Older and sicker workers, especially those with low incomes, would generally be made worse off by having to shoulder a greater percentage of the costs of their care than they do now. As a result, some of them likely will lose access to some important medical services they need.

Enactment of the proposed HSA-related tax deduction would not only further increase participation in HSAs, intensifying the risks of adverse selection, but would also be likely to increase the ranks of the uninsured by creating financial incentives for employers no longer to offer coverage to their workers. Finally, enactment of tax policies that build on the HSA precedent of providing both tax-free contributions and tax-free withdrawals would worsen an already exceedingly bleak long-term federal fiscal outlook.

The CHAIRMAN. Thank you very much, Mr. Greenstein.
Now let me turn to Kate Sullivan, who is the executive director for Health Policy at the U.S. Chamber of Commerce. Welcome.

**STATEMENT OF KATE SULLIVAN, EXECUTIVE DIRECTOR,
HEALTH CARE POLICY, U.S. CHAMBER OF COMMERCE,
WASHINGTON, DC**

Ms. SULLIVAN. Thank you, Mr. Chairman, Senator Breaux, for the opportunity to testify at today's hearing.

Enactment last year of HSAs came at a very critical time for our Nation's employers, working families, and those who buy their own health coverage. They all have been facing enormous challenges finding those affordable plans. Along with injecting new and much needed competition for employers' premium dollars, HSA's offer a number of advantages for employees. Of primary benefit the account is held by the taxpayer rather than the employer as some of the other consumer-directed plans require. Employers and employees may contribute to the HSA, easing concerns that younger or less affluent workers may have about funding their deductibles. I am happy to report in a moment that employers overwhelmingly plan to do just this, make those contributions.

As with other compensation requirements, employer contributions must be made fairly across the employee base, and HIPAA requirements for pre-existing conditions will require that contributions not be varied based on an employee's health status. HSAs have already jump started the small group insurance market for 2004, and small businesses desperately needed this market competition for their increasingly huge premium dollar.

The benefits planning enrollment cycle for larger employers had already been completed by the times HSAs were enacted last December, so 2005 is the first time that these employers can even think about adding this option. That cycle is now just getting under way, and we appreciate very much the Treasury Department's efforts to recognize these deadlines employers have in getting a series of very important guidances out to the employee benefit planning community.

As I have said, employers are getting ready to incorporate HSAs into their benefit offerings, and a recent Mercer Consulting survey found that 2 out of 5 employers are likely to offer this option next year, nearly three-quarters will at least offer this an option by 2006. Nineteen percent of employers said that they already offer such a plan. They have already had a deductible of that level, predominantly very small businesses and very large entities. Because of the transition rules that Treasury has put in place for 2005 and this year, informed and motivated employees can go ahead and set up these HSA savings vehicles in the absence of formal sponsorship by their employers.

While some employers had already adopted high deductibles in recent years due to these rising costs in premiums, many employers in the survey reported that they intend to contribute at least in part to these accounts, deflating some critics' arguments that HSAs will simply shift more cost to employees. Most employers intend to adopt only the minimum \$1,000 deductible. A quarter said they would contribute \$500 to the saving accounts, 17 percent had

said they would contribute 1,000 above and beyond what they already paid for the premiums, and a number are going to contribute the maximum \$2,600, so really the employee would not even feel a deductible. The average contribution would be over \$1,000, \$1,089. Three out of four employers would contribute an amount lower than the deductible amount to make sure that there is still some kind of deductible consistency policy with what they are doing now, while another 13 percent said they would contribute fully to that deductible.

We have been waiting for these guidances from Treasury, and the most recent guidance dealt with two important issues, how employees may continue to use their flexible spending accounts for things that are not covered by the health plan, which they made clear they can continue to do, along with existing health reimbursement arrangements so long as these do not cover the deductible. However, employees must budget carefully because any unspent money, as employees are all too familiar with, will prompt a quick run to the optical store to make sure you stock up on contact lenses for the next year. I see lots of heads nodding around the room. So this is something we are familiar with. We hope the Senate will follow the lead of the House last week, and allow employees to roll over at least \$500 of these funds.

We do have a barrier though that deals with how prescription drugs are treated under the deductible. The HSA law does not follow what is very well established practice in employee benefits management, which is to keep prescription drugs separate from overall medical spending. We are very concerned that after 2005, through which Treasury has provided transitional relief, that subjecting prescription drugs to this deductible will trigger medical plan spending much more quickly. That will drive up the health plan cost, and employers will be forced to raise that premium, and the deductible much higher.

There are advantages in the law for older workers, something I know this committee is very concerned with, and provides an opportunity to restore retiree health benefits planning. In fact, more than a third of small businesses who do not now offer retiree benefits said they view HSAs as a way to help their employees with those very significant expenses for even after you attain Medicare age.

Finally, I would just like to note that putting more in tax incentives toward individuals does not mean employers are going to drop coverage. There is a lot that has to happen in the individual market in order to make sure that employees have a place to go. Employers are not going to drop coverage if they do not think all of their employees can safely get into a plan.

The real enemy of what is happening with these policies is cost. If they get too expensive and we do not bring down costs, we are going to have a huge problem with people having no coverage in this country.

Thank you very much.

[The prepared statement of Ms. Sullivan follows:]



Statement of the U.S. Chamber of Commerce

ON: "HEALTH SAVINGS ACCOUNTS AND THE NEW
MEDICARE LAW: THE FACE OF HEALTH CARE'S
FUTURE?"

TO: SENATE SPECIAL COMMITTEE ON AGING

BY: KATE SULLIVAN

DATE: MAY 19, 2004

The Chamber's mission is to advance human progress through an economic,
political and social system based on individual freedom,
incentive, initiative, opportunity and responsibility.

The U.S. Chamber of Commerce is the world's largest business federation, representing more than three million businesses and organizations of every size, sector, and region.

More than 96 percent of the Chamber's members are small businesses with 100 or fewer employees, 70 percent of which have 10 or fewer employees. Yet, virtually all of the nation's largest companies are also active members. We are particularly cognizant of the problems of smaller businesses, as well as issues facing the business community at large.

Besides representing a cross-section of the American business community in terms of number of employees, the Chamber represents a wide management spectrum by type of business and location. Each major classification of American business—manufacturing, retailing, services, construction, wholesaling, and finance—is represented. Also, the Chamber has substantial membership in all 50 states.

The Chamber's international reach is substantial as well. It believes that global interdependence provides an opportunity, not a threat. In addition to the U.S. Chamber of Commerce's 96 American Chambers of Commerce abroad, an increasing number of members are engaged in the export and import of both goods and services and have ongoing investment activities. The Chamber favors strengthened international competitiveness and opposes artificial U.S. and foreign barriers to international business.

Positions on national issues are developed by a cross-section of Chamber members serving on committees, subcommittees, and task forces. More than 1,000 business people participate in this process.

**Testimony of
Kate Sullivan
Executive Director, Health Care Policy
U.S. Chamber of Commerce**

**before the
United States Senate
Special Committee on Aging
“Health Savings Accounts and the New Medicare Law:
The Face of Health Care’s Future?”
May 19, 2004**

The U.S. Chamber of Commerce is pleased to testify at today’s hearing about the benefits of Health Savings Accounts. I am Kate Sullivan, the Chamber’s executive director of health care policy, and I have been involved in health care policy for 18 years as a staff advisor in the U.S. House of Representatives, to a former state governor and in various capacities in the private sector. The U.S. Chamber of Commerce is the world’s largest business federation representing employers of every size, sector and region, and has been engaged for a number of years in advocating that all Americans have health coverage through an appropriate mix of market reforms, public financing and a meaningful safety net. Moreover, everyone in this country, whether privately covered, publicly subsidized or uninsured, has a right to expect that our health system has at its root the best possible quality with uncompromising standards of safety.

Enactment last year of Health Savings Accounts (“HSAs”) came at a critical time for America’s employers, working families and those who buy their own health

coverage, all of whom face challenges due to the increasing costs of health plans. HSAs offer a great many advantages for employers of all sizes and to workers at any point in their lives—particularly at those times when they are not working. I will discuss the importance of ensuring healthy market competition, into which HSAs are a welcome entrant, to help lower health care costs and improve our health care system, and to discuss the outlook of HSAs in the employee benefits arena and for older workers. Regardless of how one arranges his health coverage, however, we understand that an ideal health system involves many elements that must work together, a few components of which are private sector choices, effective use of the tax code, and greater use of disclosure information.

Reducing Health Insurance Costs through Market Competition

The insurance market, particularly for small businesses, has largely stagnated over the last five years. Time and time again since the late 1990s, small businesses have been forced to get a new health plan because their insurer has left the marketplace. Other employers have found that they have no other insurers in their area to call for a rate quote when their current plan premiums skyrocket. This lack of competition stems from state mandates on health plans, which have taken away health plans' ability to differentiate themselves in the marketplace and compete for customers by offering benefits tailored to meet their needs. When carriers leave the market, they leave employers with one less place to go with their business, and concentrate the market power of one or two dominant insurance companies. Health Savings Accounts hold the promise of reviving the largely moribund but costly small business insurance market.

HSAs were established in the Medicare prescription drug law and went into effect on January 1, 2004, and will replace their more restrictive Archer MSA

predecessor. While a number of larger employers have experimented with so-called “consumer-driven health plans” made possible by health reimbursement arrangements (“HRAs”), non-discrimination compensation testing largely prohibits these plan designs for some small businesses and partnership arrangements.

The HSA Advantage

Along with injecting new competition for employers’ premium dollars, HSAs also offer a number of advantages for employees. Of primary benefit, the account is held exclusively by the taxpayer, rather than the employer. Employers may contribute to the HSA (as may the employee), easing concerns for younger or less affluent workers about funding their deductibles. As with other compensation requirements, employer contributions must be made fairly across the employee base, and HIPAA requirements for preexisting conditions will require that contributions not vary based on an employee’s health status.

The Small Group Market. HSAs have already jump started the small group health insurance market in 2004. Many small businesses had already been forced to adopt higher deductible health plans as insurance costs nearly doubled over the last five years. Insurers specializing in these kinds of health plans are reentering states where they had once done business and left, or are becoming new market alternatives to the one dominant insurance carrier serving the small group market in a given area. Traditional insurers are also offering HSA products in an effort to retain small business customers. Small businesses desperately need this market competition for their substantial premium dollar.

The Large Employer Market. Because the benefits planning and enrollment cycle for larger employers had long been completed by the time HSAs were enacted last December, 2005 is the first year many of these employers can contemplate adding

this option to their array of benefit offerings. The earliest stages of the 2005 planning cycle are now just getting underway for most companies and will continue through this summer. Typically, employees make their selections in the autumn months. The Treasury Department is to be commended for recognizing the realities of the employee benefits calendar and working to issue guidances to employers and their consultants in time for the 2005 cycle.

The Individual Market. HSAs are also an option for those without employer-sponsored coverage. For certain individuals, HSAs also offer a pre-tax mechanism for paying for the required accompanying high-deductible health plan insurance when the account holder does not have workplace coverage, the first time the tax code has made this allowance. Premiums may be paid from HSA balances, though annual contributions are still restricted to the amount of the annual deductible. Therefore, greater tax code equity changes must still be made. President Bush and Congressman Phil Crane have put forth important proposals allowing all individuals who purchase their own high-deductible health plans to deduct their insurance premiums.

HSAs as an Employee Benefit Option

Employers are getting ready to incorporate HSAs into their employee benefit offerings. A recent Mercer Consulting survey of nearly 1,000 employers this past March found that while two out of five employers were likely to offer an HSA option next year (less than 10% reported that they were “very likely” to do so), nearly three-quarters said they were likely to do so in 2006 (with one out of five saying they were “very likely” to offer an HSA then).

Already, 19% of respondents said they offer a high-deductible health plan to their employees, predominantly very small businesses (32% of those with 10-49 employees) and very large entities (28% of those with more than 20,000 employees).

Because of transition rules put forth by the Treasury Department for 2005 and 2006, informed and motivated employees could establish their own HSA savings vehicle in the absence of formal sponsorship by their employers.

Employer Contributions to HSAs. While some employers had already adopted higher deductibles in recent years due to rising costs and premiums, many employers in the Mercer survey reported that they intended to contribute at least in part to an employee's health savings accounts, deflating some critics' arguments that HSAs will simply shift more costs to employees.

- First, most employers (61%) intended to adopt only the minimum \$1,000 deductible (for single coverage), while only 10% would establish a deductible above \$2,000.
- Then, about a fourth (24%) said they would contribute \$500 to the savings account, 17% would contribute \$1,000, 5% would contribute \$1,500, and 6% would contribute the maximum \$2,600.
- For 77% of employers, their contribution amount was lower than the deductible amount they selected, while another 13% would contribute fully to the deductible.
- Among those reporting that they would make a contribution, the average amount was \$1,089.
- Interestingly, the smallest businesses (those with 10 to 49 employees) reported the highest expected contributions (\$1,560).
- Of employers contemplating HSAs, 39% did not plan to contribute to the savings account of employees.

Transition Guidance from Treasury Has Been Essential

Employers of all sizes have been waiting for the Treasury Department's guidances before establishing these plan options, three of which have already been issued.

Flexible Spending Accounts and Health Reimbursement Arrangements. The most recent departmental guidance discussed the interaction of HSAs with Flexible Spending Accounts, which are commonly used to pay out-of-pocket deductibles and copayments as well as non-covered services, supplies and over-the-counter medications. In short, employees will continue to avail themselves of FSAs so long as these accounts—as well as consumer-centered Health Reimbursement Arrangements—are restricted to benefits for vision, dental or preventive care, or are used to cover expenses in excess of the annual deductible. However, employees must still budget carefully because unspent funds at the end of the year are forfeited to the employer. Consequently, only 34 % of eligible employees participate in their workplace FSA, and many under-budget their need.

We hope the Senate will follow the House's action last week and modify the so-called FSA "forfeiture" rule. By allowing a rollover of unspent funds to the next year's FSA or to an HSA if one is available, employees will be less likely to embark on a spending spree of unneeded medical, dental or vision services and supplies. To reduce the cost of such a change in policy, the U.S. Chamber of Commerce strongly urges lawmakers to allow employees the option of withdrawing any amount of their funds on an after-tax basis. The U.S. Treasury currently forfeits income and payroll taxes on unspent funds that revert to the employer, and the House-passed bill does not contain this option.

Making HSAs Work in 2004 and 2005: Banks and Rx Benefits. As many employers had already adopted high-deductible health plans if not HSAs as the Congress later envisioned them, individual employees enrolled in these plan options could establish a qualified account on their own. However, two significant barriers have prevented this from happening. First, many financial institutions where employees may already bank, maintain an IRA or hold their investments, are not yet offering qualified accounts. Treasury has therefore given individuals until next April 15 (of 2005) to establish and account for 2004 and 2005. We are pleased that many health plans are also working to establish proprietary banking options to facilitate FSAs for their employer clients.

The second barrier has been the treatment of prescription drugs relative to the medical plan's deductible. Most health plans, and nearly all employer-based plans, manage prescription drug benefits separately from other medical benefits in an effort to contain rapid expenditure growth over the last five years. These plans utilize formularies and a schedule of fixed-dollar copayments or percentage coinsurance to encourage the use of the most cost-effective and clinically appropriate medication. Many of these medically necessary drugs help users to avoid more costly medical services. Unfortunately, HSA law does not allow health plans to "carve out" prescription drugs from the health plan.

The Treasury Department's March guidance provides transitional relief through 2005. However, beginning in 2006—absent a change in the HSA law—employers must re-vamp their benefits significantly in order to bring prescription drugs under their overall medical deductible thresholds. Despite the Mercer survey, which was conducted prior to Treasury's most recent guidance and further study of the matter by employee benefit professionals, few employers report that they are likely to adopt HSAs until this matter is resolved permanently, which would require legislation.

Moreover, subjecting prescription drugs to the deductible would trigger more expensive medical benefits coverage above the deductible much sooner, resulting in either higher health plan expenses and premiums, or forcing employers to adopt even higher deductibles for their HSA options, which could dampen employees' enthusiasm for them. We urge the Congress to take action well before May 2005, when employers are planning for 2006, to exempt prescription drugs from the high-deductible requirement of HSAs.

HSA Advantages for Older Workers

It is no secret that employers have scaled back retiree health coverage in recent years as health plan expenses have soared and threatened the affordability of coverage for active employees. The HSA law offers the ability of older workers (those aged 55 to 64) to contribute additional funds above the deductible in preparation for their necessary medical expenses once they attain Medicare eligibility. A recent study by the Employee Benefits Research Institute finds that working age Americans are ill-prepared to manage the staggering cost of their personal financial obligations for medical care once they retire. Just as today's workers need to plan at a young age for retirement income and not rely solely on Social Security, they must also plan for medical costs that Medicare will not cover. Nearly half of employers with more than 500 employees in the Mercer HSA survey report that they view HSAs as a savings vehicle for post-retirement medical coverage, while more than one-third (36%) of smaller employers—who are far less likely to offer retiree health coverage—report this motivation for offering an HSA.

Reducing Health Care Costs through Better Information

To work most effectively, all health system consumers, but especially those with HSAs and other plan designs which encourage active consumer behavior, must

have far better information about the medical delivery system than that which exists today. Information is an important component to reducing costs and ensuring good outcomes—whether that information is about provider performance, best treatment options, available health plan choices or ways to improve one’s own personal health. Components of better information to improve quality and lower costs include:

- Sharing information about provider performance;
- Developing evidence-based protocols to reduce practice variation;
- Eliminating medical errors through greater use of technology-based information systems;
- Steering patients to providers dedicated to quality improvement and best practices; and
- Disclosing the cost of items and services so patients can, when appropriate, compare prices relative to benefit.

Further research into clinical treatment protocols will enhance patient care, reduce practice variation and health care disparities, and improve patient outcome. This research should be supported in the public and private sectors, its results widely disseminated, and the ensuing protocols incorporated into reimbursement systems. Providers should be rewarded for being efficient and treating patients successfully the first time; the current system pays to correct each medical complication, side effect and even error. Employers do not wish to spend their health care dollars in such haphazard fashion, and some are revising their payment systems to promote efficient care. Medicare is also experimenting with such an approach, and we encourage these developments.

Similarly, employers have demanded greater use of technology based systems for patient care, resulting in more electronic records and prescription ordering,

minimizing the chance of handwriting errors and speeding information retrieval in easily sorted formats.

HSAs and Tax Incentives Augment, not Undermine, Employer Coverage

Critics of market-based health care solutions are working overtime to convince policymakers that the widespread use of Health Savings Accounts and health insurance tax incentives aimed at individuals will undermine the employer-based health system. In fact, such windmill-tilting exercises divert attention from the true enemy of the system of which 136 million American employees of private employers and their dependents rely: COST.

No longer can employers allow dollars that should go into paychecks—and eventually to be recirculated into the economy—instead go to insurance premiums and the health system as a whole when so little accountability is demanded. HSAs and their companion health plans can improve this situation, and return more of one's paycheck to other sectors of the economy.

The CHAIRMAN. Kate, thank you very much.

Now let us turn to Dr. Ed Langston, who is a trustee of the American Medical Association, longstanding service to the organization as a practicing family physician from Lafayette, IN.

Dr. Langston, welcome to the committee.

**STATEMENT OF EDWARD L. LANGSTON, M.D., TRUSTEE,
AMERICAN MEDICAL ASSOCIATION, LAFAYETTE, IN**

Dr. LANGSTON. Thank you, Mr. Chairman, Senator Breaux. It is a pleasure to be here. I am Dr. Edward Langston, a practicing family physician, as noted, in Lafayette, IN. On behalf of the Association's members, thank you for the opportunity to share our views regarding the newly created Health Savings Accounts.

AMA has long been a champion of this consumer-driven health care option because Health Savings Accounts provide, (1), greater patient control and choice over the use of health services; (2), incentives to utilize health care in a cost-conscious manner; (3), support for the patient-physician relationship; and (4), affordable protection against medical costs.

The establishment of the Health Savings Accounts is just part of an overall trend toward consumer-directed health. Consumer-directed health care provides patients with greater control over health care decisionmaking. It also provides patients with a clearer understanding of health care costs.

We anticipate that Health Savings Accounts will enhance the patient-physician relationship because high-deductible health insurance reduces outside interference with treatment decisions while providing patients and physicians an incentive to avoid wasteful spending. When patients spend money from their Health Savings Account, there is a strong incentive, to balance the costs of medical procedures and care against the potential favorable impact on their health. This is true both for patients and for physicians.

These cost incentives reduce the need for managed care rules that limit availability of care. This provides individuals with greater flexibility in choosing the care that they require and desire, and we hope this will reduce managed care interference in treatment decisions.

A Health Savings Account will assist the uninsured. For workers whose employers do not offer health insurance, a group that accounts for the majority of the uninsured, Health Savings Accounts are an attractive opportunity.

Health Savings Accounts also have the potential to expand coverage by funding premium payments for the recently unemployed under COBRA or the individual market.

Furthermore, due to their tax-advantaged status, Health Savings Accounts allow consumers to maximize their health care dollars, i.e., building savings for future health care needs, as we heard earlier.

We know that high-deductible insurance has lower premiums than other insurance plans. Therefore, it makes health insurance affordable for some who previously were priced out of the market. Health Savings Accounts may be more affordable than conventional coverage for patients with higher expenses for two additional reasons. One, the out-of-pocket limit serves as a powerful protection

against catastrophic expenses, and second, out-of-pocket expenses funded by a Health Savings Account are paid for by untaxed dollars. In fact, some patients will find a Health Savings Account less expensive than other health insurance plans regardless of their medical expenses.

In closing, we suggest additional measures which could make Health Savings Accounts even more attractive. First, we urge Congress to explore allowing early retirees and the unemployed who are not receiving unemployment compensation to use their Health Savings Account funds to pay for health patient premiums without tax or penalty. We see this as a way to assist those in financial need to purchase the health insurance they do need.

Second, we support tax-free rollovers for unspent Flexible Savings Account funds to go into the Health Savings Account, thus promoting more prudent health care spending by curtailing the "use it or lose it" mentality which is promoted by our current laws.

Finally, we support a new option for Health Savings Accounts that would allow a more flexible deductible for families, that is, lower per-person deductibles for individual family members. I would be happy to elaborate on that during the question and answers if you so choose.

But I want to thank you for exploring the issue of consumer-driven health care and in particular Health Savings Accounts. I especially thank the committee for holding this hearing and continue to focus attention on the nation's health, particularly the health of older and/or retired Americans. Thank you, Mr. Chairman.

The CHAIRMAN. Doctor, thank you very much.

[The prepared statement of Dr. Langston follows:]

American Medical Association

Physicians dedicated to the health of America



1101 Vermont Avenue, NW
Washington, DC 20005

Statement

to the

Special Committee on Aging
United States Senate

**Re: Health Savings Accounts
and the New Medicare Law:
The Face of Health Care's Future?**

Presented by: Edward L. Langston, MD

May 19, 2004

Division of Legislative Counsel
202 789-7426

TESTIMONY

of the

American Medical Association

before the

**Special Committee on Aging
United States Senate****RE: "Health Saving Accounts and the New Medicare Law:
The Face of Health Care's Future?"****May 19, 2004**

Mr. Chairman, my name is Edward L. Langston, MD, Trustee of the American Medical Association (AMA). I am a practicing family physician in Lafayette, Indiana. On behalf of the Association and its physician and student members, I thank you for the opportunity to share our views with the Committee regarding newly created Health Savings Accounts (HSAs), which are an expansion of their predecessor, Medical Savings Accounts (MSAs). We especially thank this Committee for holding this hearing and continuing to focus attention on the nation's health, particularly the health of older and/or retired Americans.

The AMA has long been a champion of MSAs, a consumer-driven health care option. They provide affordable protection against high medical costs, greater patient control over use of health services, assistance with the patient-physician relationship, and incentives to utilize health care in a cost-conscious manner. We support the newly created HSAs, and we are appreciative of the U.S. Department of the Treasury's and U.S. Department of Labor's timely issuance of their regulatory guidelines.

A main element of AMA's proposal for expanding health insurance coverage is creating opportunities for individuals and families to access alternative markets for the purchase of individually owned health insurance. This hearing is an important step in exploring such consumer-driven health care options for our nation.

AMA Supports HSAs

Both MSAs and HSAs are a form of health insurance coverage that includes a high-deductible insurance plan coupled with a tax-advantaged personal savings account to be used only for qualified medical expenses. Under the options, patients have incentives to utilize health care in a cost-conscious manner because they spend from their own accounts and/or out-of-pocket before meeting the deductible. Unspent account balances accumulate and accrue interest from year-to-year. High deductibles keep premiums low, making coverage more affordable than traditional insurance and freeing up monies to fund the accounts. Once the deductible has been met, coverage resembles conventional insurance. HSAs can result in administrative savings to the extent that services utilized before the deductible are not sent through claims processing. Account funds also can finance long-term care with untaxed dollars and serve as retirement savings for non-medical expenses, though subject to income tax upon withdrawal.

According to the Internal Revenue Service, nearly 75% of MSA enrollees had been previously uninsured. The AMA and other MSA supporters sought to make MSAs permanent and eliminate restrictions hindering their growth. Legislation passed in 2001 and 2002 renewed the MSA demonstration through the end of 2003. In December 2003, the “Medicare Prescription Drug, Improvement, and Modernization Act” (P.L. 108-173) (MMA) established HSAs effective January 1, 2004, thereby removing most MSA restrictions. The establishment of HSAs is part of an overall trend toward consumer-directed health care, in which patients have greater control over health care decision-making and gain a better understanding of the financial consequences of their decisions.

Almost immediately after the passage of the MMA, the U.S. Department of the Treasury issued guidance on the implementation of HSAs, followed by further guidance from the Department in March 2004 and May 2004. The U.S. Department of Labor issued its Field Assistance Bulletin in April 2004. Treasury has stated that it will release more formalized guidance or regulations in 2005.

Since the authorization of HSAs, employers, insurers, financial institutions, policy makers, and the media have shown intense interest in HSAs. We are hopeful that HSAs will assist with restraining health care utilization, exerting competitive pressure on prices, and forcing transparency of pricing. We are encouraged that HSAs possibly will cut the ranks of the uninsured, boost innovation in benefit design, and spur demand for cost-containing medical technology. Moreover, we anticipate that HSAs could reduce managed care interference in treatment decisions and restore the patient-physician relationship.

The AMA supports the permanent establishment of HSAs by the “Medicare Prescription Drug, Improvement, and Modernization Act” and subsequent regulatory guidance. The statute and regulations substantially achieve many of the AMA’s policy objectives for MSAs/HSAs. We especially support the following elements of HSAs:

- Repealing the limit on the number of MSAs (hereafter called HSAs) and removing the demonstration status of the project;
- Expanding eligibility to employees of any size employer and to any individual;
- Allowing both employees and employers to contribute to HSAs;
- Allowing annual HSA deposits up to 100% of the deductible, with no limit on the fraction that can be deposited at any time during the year;
- Reducing the permitted annual minimum deductibles and allowing higher annual maximum deductibles;
- Allowing HSAs to be offered in cafeteria plans provided by employers;
- Extending a “safe harbor” to high-deductible plans in all states to allow for the coverage of preventive services regardless of whether the deductible has been met; and
- Making HSAs available from a wide variety of sources, including banks, brokerage houses, and health insurers.

HSAs Enhance the Patient-Physician Relationship

High-deductible health insurance policies provide patients and their physicians an incentive to avoid wasteful health spending. When spending comes from the patient’s personal HSA, patients and their physicians have a strong incentive to balance the costs of medical procedures against the potential favorable impact on health. The same enticement can influence the choice among hospitals and among different prescription drugs. Because these cost incentives reduce the need for HMO rules that limit the availability of care, individuals can have greater flexibility for choosing the care that they want. In short,

the new HSA tax and insurance rules may be the beginning of successfully controlling medical spending and bringing it in line with the best interests of patients.

Effects of HSAs on Cost and Access

Demand for HSAs Among Individuals

The loosening of eligibility restrictions vastly increases the potential market for HSAs. Eventually, demand for HSAs is likely to be particularly strong among workers whose employers do not offer health insurance benefits – the group that accounts for the majority of the uninsured. During the first week of 2004, one insurer received over 1,000 applications for HSAs, and during the first six weeks of the year, 30% of their new HSA enrollees were among the *previously uninsured*. HSAs also have the potential to expand coverage by funding premium payments for workers who lose their jobs.

The lowering of required deductibles also makes HSAs appeal to more people, especially given that there is already a trend toward higher deductibles. Given limits on out-of-pocket expenditures, even frequent utilizers of health care services could be attracted to HSAs as a means of wresting control over health care decisions from managed care insurers. The fact that HSA health plans are now permitted to exempt a wide array of preventive services from the high-deductible will also make HSAs more attractive to many individuals and families. It should be noted that some analysts worry that families might be deterred from purchasing an HSA because, in contrast with insurance industry norms, plans generally may not apply lower embedded individual deductibles to individual family members.

Individuals will be attracted to HSAs both for insurance coverage and as an investment vehicle, since HSA contributions and interest earnings are not taxed and individuals own and control the investment choices. Even if HSA funds are not rolled over to the following year, the individual reaps a tax advantage by paying for out-of-pocket medical expenses with untaxed dollars. The tax advantages of HSAs, although generally greater for those in higher tax brackets, are substantial for anyone earning enough to pay income taxes.

Demand for HSAs Among Employers

Employers seeking to rein in rapidly escalating health benefit costs – or simply offer health benefits – will be attracted to HSAs. In a 2003 survey of small business owners conducted by the National Small Business Association, 73% of respondents reported that HSAs would appeal to their employees. A recent survey of large employers indicates rapid growth in the number of firms offering employees a consumer-driven health care plan.

Because of the timing of the HSA regulatory guidance relative to open-enrollment periods, some employers were unable to offer HSAs in 2004; yet there is expected to be a large wave of employers offering HSAs in 2005. In April 2004, the federal Office of Personnel Management announced that, starting in 2005, HSAs will be offered to the nearly nine million federal employees and their dependents covered through the Federal Employees Health Benefits Program. Employers offering HSAs alongside other health plan choices are likely to adjust premiums and benefits in order to mitigate any adverse selection across plans.

Supply of HSAs by the Insurance and Financial Services Industries

In early 2004, demand for HSAs on the individual market seemed to outpace supply, with some individuals having difficulty finding knowledgeable, qualified banks or other institutions with which to establish accounts (hence, the Department of Treasury granted transition relief guidance allowing extra time to establish HSAs). Many insurers planning to market HSA accounts along with their insurance

plans will start by offering simple accounts and later offering more sophisticated investment options. At least one company already plans to issue debit cards for HSA, MSA, and Flexible Spending Arrangements (FSA) that would verify patient eligibility and track deductibles. Although some insurers are awaiting final regulatory guidance, most industry experts expect the availability of HSA plans and accounts to expand rapidly, as was the case following the liberalization of IRA eligibility restrictions in 1981.

In a recent survey of insurers serving employer groups, 42% of respondents reported having an HSA product either ready or under development, with another 25% considering entering the HSA market. The first insurers offering qualifying high-deductible health plans have been companies already offering MSAs or Health Reimbursement Accounts (HRAs). The large carriers tend to offer plans with a wide range of benefit designs, some already complying with HSA requirements. Large carriers were already positioned to serve as HSA account custodians and to educate and mobilize brokers to market HSAs. Large carriers also are reportedly working with large employers to develop sophisticated benefits packages that integrate HSAs with HRAs and/or FSAs, to the extent that the Department of Treasury Guidance permit such arrangements.

Criticisms of HSAs Appear to be Unfounded

The major criticism of HSAs is that they are only for the “healthy and wealthy.” Based on the limited available evidence to-date from MSAs and HRAs, *this concern has not been borne out*. A simulation model developed by the RAND Corporation suggested that MSAs would not disproportionately attract younger, healthier individuals. At a February 2004 Galen Institute forum on consumer-directed health care, six insurers presented data showing that HRA enrollees were older and of slightly poorer health status as those opting for other forms of coverage. Similarly, there is evidence that, despite chronic conditions or high medical expenses, some people are attracted to HRAs because they gain greater control over health care decisions than under conventional managed care plans.

Calculations conducted by the AMA show that the annual cost of an HSA compared to a PPO plan depends on health plan premiums, deductibles, coinsurance, and out-of-pocket limits, as well as individual medical expenses and tax bracket. Not surprisingly, individuals with little or no medical expense generally save money with an HSA because of the premium difference. Individuals with moderate to high medical expenses are more likely to find the PPO less expensive. However, two factors in addition to low premiums could make an HSA more affordable than conventional coverage even for those with higher expenses. First, although generally higher than PPO out-of-pocket limits, the HSA out-of-pocket limit serves as a powerful protection against catastrophic loss. Second, out-of-pocket expenses funded by an HSA are paid for with untaxed dollars. Because of this tax advantage, some individuals may find an HSA less expensive than the PPO regardless of their medical expenses.

One must consider how an HSA compares to alternative health plans. People with high medical expenses will pay attention not only to their overall costs – which could be lower with an HSA than conventional coverage – but also to gaining greater choice and control over physicians and treatment decisions, an advantage of HSAs.

Future Congressional Action

The AMA strongly supports the newly created HSAs. As previously stressed, we applaud both the statute and corresponding Guidance provided through the regulatory process through the Department of Treasury

and the Department of Labor. Additionally, AMA supports the following which would make HSAs even more attractive to patients:

- Allowing early retirees and others who are unemployed but not receiving unemployment compensation to use account funds to pay for high-deductible health insurance premiums, without being taxed or penalized the 10% fee.
- Allowing patients to receive tax-free rollovers of unspent Flexible Spending Arrangement (FSA) funds to go into a FSA or into a HSA. This would promote more prudent healthcare spending by curtailing the “use it or lose it” mentality promoted by current law.
- Allowing high-deductible health insurance plans issued to families in conjunction with HSAs to apply lower, per-person deductibles to individual family members with: (1) the permitted levels for per-person deductibles being the same as permitted levels for individual deductibles; and (2) the annual HSA account contribution limit being determined by the full family deductible or the dollar-limit for family policies.

AMA Thanks the Committee

We thank the Committee for exploring the issue of consumer-driven health care and in particular HSAs. We look forward to working with the Committee on the issue of HSAs and other important health care objectives.

The CHAIRMAN. Obviously, one of the concerns expressed by critics of this is the concept of adverse selection and the attracting of only the healthier and the wealthier. Yet, the actual claims-based data indicates that consumer choice options like HSAs actually show no evidence yet of meaningful adverse selection.

What is each of your assessments of that particular question? Of course, we will allow you to join in on that, Mr. Greenstein. Mr. Goodman?

Mr. GOODMAN. Well, let me just briefly describe what we did for our own employees. We created a \$1,500 deductible and we put \$1,000 in a Medical Savings Account for each employee and their families. So the person who is healthy and never has a single medical expense at the end of the year had \$1,000 in his account. Since this was previously taxed, they got to take the money home at Christmas time. So yes, the healthy person gets his \$1,000.

But the person who is really sick and has lots of medical expenses goes through the \$1,000, pays \$500 out of pocket, and then hits the deductible and the plan pays for everything above that. But before we had the Medical Savings Account plan, we had a conventional plan with a \$500 deductible and 20 percent copayment, and when the sick person was under that plan—it was a woman in this case—she was out \$1,500. So the sick person saved \$1,000 on medical expenses because the exposure was limited under our plan.

There is nothing unusual about our plan. This is the way over the last 7 years that most Medical Savings Account plans were structured. They really do benefit the high-cost employee because they limit out-of-pocket exposure even though they don't buildup anything in the account.

The CHAIRMAN. Mr. Williams.

Mr. WILLIAMS. Yes. I would say that our experience is in working with very large employers who really often self-insure and therefore assume the insurance risks themselves, who are interested in having a productive and effective workforce and who see this as one way to get the workforce thinking about the cost of health care and discussing different options with their physicians for more cost-effective health care treatment.

I would say our experience is that we do not see adverse selection. We think that consumers make choices for different products based on lots of considerations. Their health status may be one, but there are lots of others. We don't see any data today that would suggest an adverse selection.

We think that there is a larger percentage of health care costs that is discretionary than many individuals believe. This is not the individual who has a cardiac event or who has a significant health episode. We are talking about the person who has a fairly minor situation and can have a choice in do they go to their physician and get the care they need, do they go to an urgent care center and get the care they need, or do they go to an emergency room and get the care they need. In those circumstances, there are very different cost structures and implications for the underlying increase in health care costs and, therefore, for the efficiency of American business.

The CHAIRMAN. Mr. Greenstein.

Mr. GREENSTEIN. In fact, there really are virtually no claims-based data on widespread use of something like HSAs. There are some limited data from HRAs. But the differences are so significant that I don't think you can simply apply the HRA data.

As I noted, because the HRAs do not allow tax-deductible deposits by the employee into them and do not provide a way to buildup retirement savings that can then be withdrawn in retirement for non-health care costs with tax advantages, the tax sheltering aspect of HRAs pale in comparison to HSAs and it is in significant part this very generous tax shelter and the incentive it provides for healthier, more affluent people to go into HSAs that drives the adverse selection concerns.

Now, in 1996, Congress set up an MSA demonstration project and part of the purpose, a central part of the purpose was to determine whether there are or there are not these adverse selection aspects that result from these kinds of accounts. Unfortunately, what happened was that the use of MSAs was so limited under that demonstration that the GAO concluded that one couldn't tell.

The only evidence—and I will readily acknowledge this is very limited—the only thing we have is that under a survey of insurers that the GAO contracted for, the insurers said that they expected enrollees to be healthier and wealthier and were targeting their promotions accordingly. But the bottom line is, we didn't get much out of—we didn't get anything significant.

The CHAIRMAN. Well, we did get one thing, didn't we?

Mr. GREENSTEIN. Let me just quickly—

The CHAIRMAN. Go ahead.

Mr. GREENSTEIN. The bottom line is, what we really should have done last fall, in my view, is we should have said, "What are the problems with that demonstration project that led to so few people enrolling that we didn't get enough observations to determine what effect on adverse selection these accounts would have had, and we should have done a demonstration project that would have had larger enrollment and given us the answer. Instead, we charged ahead and went whole hog."

I think it is worthy of note that while we do not have significant claims-based data to tell us which side of this debate is right, that the leading studies I am aware of, the leading projection studies I am aware of were run by institutions that have no ideological ax to grind and pretty much come down on the side that the risks of adverse selection are high.

The CHAIRMAN. I was only going to make the observation that is not true that in that demonstration period, the largest group that acquired them were the uninsured?

Mr. GREENSTEIN. We don't even—

The CHAIRMAN. They were predominately the acquirers of Medical Savings Accounts?

Mr. GREENSTEIN. We don't even know that. If we look—

The CHAIRMAN. Some insurance companies tell us that. I don't know whether they are accurate or not.

Mr. GREENSTEIN. There is IRS data on this and it is inconsistent. In one year, if you use those data, 28 percent of the enrollees were previously uninsured. In another year, 40 percent. In another year,

73 percent. The differences were so substantial that those data have to be regarded as unreliable. We really don't know.

The CHAIRMAN. All right. We will leave it at that and we will go to you, Kate, to respond to the similar question of adverse selection.

Ms. SULLIVAN. I would just note that, I mean, already, we have a fifth of employers reporting that they already offer a plan that meets at this deductible threshold and they are not doing this as an HMO. It is often an HMO alternative. Perhaps if it is a small business, it might be the only plan they can find and afford.

But those higher deductibles come with a much greater flexibility. You are not restricted to a particular network of physicians with no coverage outside, and that has a lot of appeal to employees who have a medical condition, perhaps a chronic condition. They want that flexibility without getting referrals, perhaps maintaining a relationship with a physician they have had for many years. So we know that that has a lot of appeal to people who are sick, as well.

I would encourage, as we go down this road and look—here we are, supposing, based on one projection or another—let us look and see who has really been electing these plans all along. They tend to be high-utilizers as well as people who like the additional savings, like yes, I have to pay more out of my own pocket toward the deductible, but I don't have to pay as much per paycheck to be in that plan to start with.

The CHAIRMAN. Thank you. Doctor, do you wish to comment on this before I turn to Senator Breaux?

Dr. LANGSTON. Just briefly, an observation, because I see patients in the office every day and my experience has been, frankly, that they are cost sensitive but they are also very health care sensitive and they make their choices based on their needs and the situation in which they find themselves. We have seen the data from the IRS and it does range from 28 percent to a high of 70 percent, and so we would say that is a significant amount of the uninsured who then did purchase some accounts with an MSA, and with this more favorable approach, as you know, in public policy we have used tax incentives to encourage people to address issues.

Any way from a practicing physician's perspective that we can engage people into our system to provide the health care they need and do that from a preventative perspective, we would certainly support. We think this is a step in the right direction and so we encourage that you explore this and consider the expansion of it, Mr. Chair.

The CHAIRMAN. Thank you. Senator Breaux?

Senator BREAU. I thank all the members of the panel for being with us. I am not sure that it is so much consumer driven as it is tax driven. It seems to me, and I would like to ask anybody to comment on this, if it was such a great idea, why do we have to spend \$16 billion subsidizing it? Why wouldn't everybody just say, man, this is a great idea. I am going to buy a high-deductible policy. If it is that great of an idea, why can't it just stand on its own?

Mr. GOODMAN. Well, the answer—

Senator BREAU. Suppose you don't have a substitute for it. Are you telling me that it is not good enough for people to buy it because the government helps pay for it?

Mr. GOODMAN. No. The answer is that we generously subsidize third-party health insurance and we penalize saving to pay medical bills directly. What we should have is a level playing field. Congress doesn't have to spend a lot of money to create the level playing field, it just has to treat the third-party insurance and self-insurance the same way and—

Senator BREAU. Sixteen billion dollars is a lot of money. What do you mean, we don't have to spend a lot? We are spending \$16 billion on this.

Mr. GOODMAN. There are other things you could have done. You could, for example, cap the total amount of exclusion that employees get and not spend the \$16 billion. The important thing is that when people choose between how much to put in savings and how much to give to an insurer, they should make that choice on a level playing field.

Senator BREAU. OK. Well, I think it is a level playing field when the employers already can deduct 100 percent of the premiums they pay for their employees and employees don't count it as income. That is a huge deduction already.

Mr. GOODMAN. That is right.

Senator BREAU. Why do we have to increase it by \$16 billion to encourage people to buy a policy that I think is going to result in some severe adverse risk selection, not according to John Breau but according to the American Academy of Actuaries. These are the people with the green eyeshades that do this for a living. They are not Democrats. They are not Republicans. They are actuaries, and actuaries tell us that this is going to cause adverse risk selection because it is going to be a lot more attractive to a young healthy person than it is to an older person who is poor and sick.

Mr. Williams, what is the profile of the people in your company that have bought \$2,000 deductible policies? Do you have that?

Mr. WILLIAMS. Yes. I would say, Senator, that when we look at the profile of individuals who have enrolled in our Health Reimbursement Accounts, which are modeled very similar to the Health Savings in terms of a high deductible for preventive care and then an out-of-pocket maximum where the underlying health plan kicks in, when we look at each case, the average age is approximately the same for those individuals who select this plan in a choice-based setting to those individuals who don't select the plan.

Senator BREAU. But what is the age and health?

Mr. WILLIAMS. It depends on the—if we are talking about a company with an average age of, say, 35 in the workforce, the age might be 35 in the Health Reimbursement Account and approximately 35 for the profile those companies—

Senator BREAU. Most of these are, as you have said, are Aetna policies sold to large employers?

Mr. WILLIAMS. These would be typically Aetna policies sold to large national account clients.

Senator BREAU. People who have pretty good jobs.

Mr. WILLIAMS. People who have jobs where the average income distribution depends on the nature of the business. It may be serv-

ice jobs, it may be manufacturing. They are employed in all job titles and all job families.

Senator BREAU. Mr. Greenstein.

Mr. GREENSTEIN. There was a Health Affairs article a couple of years ago on survey results from the first employer that used this Aetna product and it did find that differences in earnings, higher earnings were a major predictor of more enrollment. Now, earnings tend to be higher for people who are older, although people who are older also tend to be in less good health. It could be that the earnings effect swamps the age effect. But there definitely was an earnings effect, at least in that study.

The other point, though, I would make is Mr. Goodman said, "Well, you need to have a tax treatment to equalize the treatment of this approach with the treatment of other employer-based approaches." I think that argument may well hold when applied to the Health Reimbursement Accounts that Aetna has established. But under those accounts, we didn't go one step further and provide these big tax deductions for employee contributions and then allow the whole thing to be turned into a retirement tax shelter, getting around the IRA income limit, where you can withdraw the money for non-health purposes in retirement.

So if you want to make the argument that some equalization was needed with the treatment of more traditional kind of insurance, that argument in no way means you have to go all the way to HSAs. I think it stops at HRAs, not HSAs, and there is a big difference.

Senator BREAU. I mean, I would like to have free health insurance for everybody, but obviously that is something the government can't afford and taxpayers can't afford. I am concerned that when you use the tax code in a way that encourages certain type of behavior that is not equal across the board, that that is not a fair use of the tax code, because I think this encourages certain types of activity among wealthier and healthier individuals and leaves those who cannot afford to pay that \$1,500 or \$2,000 deductible up front, and that is my concern.

Mr. GREENSTEIN. I would agree, and it is the additional features of HSAs that both make the adverse selection risk greater and that added the \$16 billion in costs that you referred to, which I agree was \$16 billion in costs we did not need to incur.

Senator BREAU. Ms. Sullivan, I would like to ask you this question about the employers because somebody has made the point that, well, let us read it in the study that was before the committee by Mr. Gruber who said, and I would ask you to comment on it because I am just not sure where he was headed. He said that the proposed tax deduction would induce some currently uninsured individuals to purchase insurance, obviously, but would also encourage some employers to drop health insurance or to reduce the amount that they contribute toward their employees' health insurance costs. Why? He says, because since employers would know that their workers could get a tax deduction if they purchase it on their own.

Employers across the board are limiting health insurance. They are dropping it for retirees or they are greatly restricting it for retirees and many companies are having an incredibly difficult time

providing it to the same degree they used to provide it to their employees.

If I am an employer and all of a sudden I see that, look, I can get out of this business and employees can get a tax deduction for buying it on their own, why in the heck wouldn't I answer to my board and do exactly that?

Ms. SULLIVAN. Because it may not be available or may not be an option for every single employee to get it on their own. You would have to know the individual market and put out some very thoughtful proposals—

Senator BREAU. These people aren't being thrown into the individual market. They can still buy it in group purchasing agreements.

Ms. SULLIVAN. If employers are no longer sponsoring, if they are getting out and saying, OK, you have to go and buy this on your own, I mean, you are right. I guess an employer could say, "I will arrange it but make zero contribution." I don't think that is something they would continue to do, particularly if it is a small employer. They don't have time to go and keep up with this arrangement.

Senator BREAU. Are people—the point she is making—are they going to be thrown into an individual market, Mr. Williams?

Mr. WILLIAMS. Well, I would say I am not sure—

Senator BREAU. That is a heck of a good argument against HSAs if they are going to say, you are going to get a Health Savings Account but you are going to be at the mercy of the market in buying in the individual market, not in group purchasing arrangements?

Mr. WILLIAMS. I think my experience, Senator, is that most employers are looking for ways to provide health insurance to maintain a healthy workforce. Whether they are a small employer or in the mid-size, they are looking for opportunities to try to make it work and—

Senator BREAU. I understand that. Individual market or group purchasing? Your point was that they may be in the individual marketplace and be at the mercy of the marketplace. Is that right on HSAs?

Ms. SULLIVAN. No. Actually, you were asking about the Gruber study, which is about the individual tax deduction proposal—

Senator BREAU. The Gruber study said employers may drop it because employees can get a tax deduction if they buy it.

Ms. SULLIVAN. If employers drop it, that means—if this is the proposal that Treasury made, to allow individuals who do buy their own insurance, who buy a high-deductible health plan to be able to deduct those premiums if they do not have employer coverage, the Gruber study says or makes an estimate as to how many employers would then drop their group plan. You would only get that tax deduction if you had an individual plan.

We don't believe HSAs at all are going to throw people into the individual insurance market. In fact, I think HSAs will help maintain employer coverage, which is for some employers barely hanging on.

I would disagree with the Gruber analysis about what the effect would be if you put more tax deductions in the tax code, tax incen-

tives for individuals. Employers are not going to drop their coverage unless they know their employees have a place to go, and they know not all employees pay taxes. Some of them don't have enough income. That is where you start looking at tax credits for that income population, to help them also be able to afford that coverage.

Senator BREAU. Thank you. My time has expired. I thank the panel.

The CHAIRMAN. Thank you, John.

I want to state an important fact for the record, because my colleague here has suggested that these kinds of tax deductions are extraordinary and somewhat unique.

Senator BREAU. Unprecedented.

The CHAIRMAN. Well, let me then suggest this. The Joint Tax Committee on Taxation estimates that in fiscal year 2003, the Federal revenue loss attributed to the exclusion for employer contributions to health insurance, which we have been doing since World War II, cost the U.S. Treasury \$75 billion. So what we have been doing, Mr. Goodman speaks to it, we have been doing it for a long time. We have just been doing it one way instead of this way.

Now we are doing it for everybody, the small employer, the large employer. I find that not unique. I find that equal. That is a different perspective than that reflected by John. But let us face the fact. There are \$75 billion worth of taxes out there that aren't being collected right now. Why? Because we believe it is good for the employer to provide for employee health insurance, and we have done that as a norm since World War II.

So different perspectives, different points of view. But Kate, I think the thing that concerns me, and John spoke to it a bit, is the commitment of the employer. My frustration in watching escalating health care costs over the years, and seeing employers agonize because of the affordability of it and the cutting back and the reshaping of the plan and ejecting the spouse out or ejecting the spouse and the family out of it. Or an employee, for example, suggesting that they would really like to move into a new opportunity and a new job but they can't afford to because the health care there is less than the one they have, and so they are locked into a health care environment or locked into a job because of the health care environment as a benefit.

I think all of us recognize the phenomenal value of health care through the employer to the employee as a tremendous benefit and an incentive. You and others on the panel argue strongly that HSAs offer significant help to the employers struggling to continue providing insurance to their employees as well as to the currently uninsured. What exactly do you believe will be the effect of the new HSA on the employer health market and on the number of the uninsured as we look at this?

Ms. SULLIVAN. In the marketplace, and we have already seen this this year for small businesses, is you have new carriers coming into States where they have not been because they are carriers that specialize in these types of plans. There has been a lot of consolidation and a lot of regulation by the States. So they pretty much have been down to one or two dominant insurance carriers in any given market.

Now there is a new guy coming in and saying, we specialize in this product. Take a look at it. Then, guess what happens. Their long-time carrier has a more traditional PPO or HMO and says—such as there has been one such company—hey, we can make this available to you also. Then all of a sudden you have got some competition for dollars. We have not seen that in years.

Those health plans also come with lower premium dollars, at lower cost, and some employers are finding that the savings is so much that they can then help fund that deductible, encouraging those younger employers who—employees who may not have the money to get into it and providing an incentive for older employees who have health conditions to also make this option because it offers more flexibility.

I think that competition is very welcome and these larger employers, as they begin planning for 2005 and 2006, are recognizing also, let us also look at some of the data on what happens with consumer behavior in terms of helping make this more affordable long-run.

The CHAIRMAN. Doctor, I think our frustration over time has been that with the third-party payment presence, that somehow the patient is kind of taken out of the picture in part. I am interested in your reaction to how doctors will look at this and the treatment of choices in relation to the patient, if that patient is there with an HSA, for example, and they are actually spending their dollars.

Dr. LANGSTON. I think one of the things that we are going to see is for instance, when patients are engaged in some of the traditional plans we have with regard to either deductibles or costs of their medications. They are much more knowledgeable and I think they ask the question, for instance, is there an alternative that will do as adequate a job at a certain price because I have a contract that would support that.

So as a clinician on a daily basis, I certainly try to accommodate the patient in making those decisions, if there are alternatives that make sense based on their contract. I am a pharmacist as well as a physician and I use a lot of generic medication in my practice. I obviously use a lot of the pioneer drugs, but that is just one area where the patient, when informed, participates in the decision-making.

The other issue is that I see patients in my office on a daily basis that decisions are made on are there some things that we can address because I am a small businessman and I have to have a very high deductible to make this work. I bought catastrophic insurance. How can I address what my needs are?

My experience over 25 years has been that every time my patient, and some would call them consumers, but my patient has been more informed about therapies and about cost, they are more engaged in their care and, I think, help make those decisions, it puts more stress on me as a physician. But quite frankly, it has made me a better doctor over the years. I now carry a PDA in one pocket and formulas in the other pocket so that if a patient has a specific request based on their contract, I can say, all right, here is the way I can make this work for you and for the medication.

I teach in the School of Pharmacy at Purdue and have pharmacy residents who rotate with me on a monthly basis, six to eight months a year, and so the young people have frankly brought me into that environment and I use it on a daily basis. If I leave my PDA at home, for instance, I am without a very efficient opportunity to see what I can do, because I can put costs in the PDA, I can put other choices in the PDA, but I also have the paper models in my other pocket.

So the patients are more informed. They participate. Anything we can do to make that happen, frankly, I think the physicians of America would be supportive. It creates change, but frankly, we have changed in the past. We will change in the future.

The CHAIRMAN. My last question, pertains long-term care. We know that in this proposal, the new HSA program provides that funds in the HSA can be used not just for regular medical expenses, but also for long-term care. That is something that we believe—I certainly believe, and I don't think my colleague disagrees with me—the more older Americans we can get onto that system, the better they are going to be, and the less impact they will have on their government as they age.

To what extent do you believe this feature may help families ease the burden of the long-term care costs? Reaction by anyone here? Doctor?

Dr. LANGSTON. If I may speak to that briefly, engaging the patient in whatever model is chosen, and this is the first step in this direction, to be involved in health care decisions is terribly important. We have a mentality, I think, in the United States of if I can take a pill or do something like that, I can certainly correct whatever my problem is.

Well, one of the interesting things when you start making decisions and spending some of your health care dollars, we might, in fact, take a hard look at some of our lifestyle issues. Let us take cardiovascular disease, the biggest killer in the United States. The five major variables there are weight, diabetes, hypertension, smoking, and cholesterol, all modifiable kinds of issues that we don't have to spend extra money on. If we can engage our patients into making that choice, and many of us believe that finding a model that has them involved in spending their own money will do that, in the long run, we are going to be better off. We think this is a step in that direction and are supportive of that. Those are big issues for us.

Mr. WILLIAMS. Senator, in response to long-term care, I think it is a very important issue. Most Americans do not have sufficient long-term care coverage.

Senator BREAU. Or any.

Mr. WILLIAMS. Most Americans are uninformed about the nature of how their long-term needs will be met. Many are confused about the nature of government programs for this. I think it is a significant accomplishment to have long-term premiums included in this and we would really advocate direct inclusion of qualified long-term care as a permitted benefit in cafeteria plans.

I think this is a huge issue and I believe that this notion of letting retirees catch up their contributions into the Health Savings Account funds would also be an important addition. There are some

acceleration features, but if you take someone today who is retiring by 2009, 2010, and you think about the \$80,000 of care that may be unfunded as a result of their inability to have thought about and provide for this earlier, there is a huge opportunity to think about giving retirees the opportunity to catch up.

We also see many people who are over 65 who are actively at work and who no longer would be able to contribute to the Health Savings Account. What we are seeing in our work is that about 50 percent of people in these type plans are rolling over funds from year to year and this is the really big idea. Consumers don't really differentiate as much between HRAs and HSAs as one might do from tax policy, particularly those people who see that as their money and think about managing it in a prudent way consistent with their health care needs, but really thinking about their long-term needs, as well.

The CHAIRMAN. Yes, Mr. Greenstein?

Mr. GREENSTEIN. Long-term care is clearly a very important issue and an unmet need. But if we try to do it through HSAs, the people who are most likely over the course of time to buildup large balances in their HSAs as they head toward their retirement years are going to be higher-income people who can afford to put a lot of money in the HSAs and to let it buildup and to not dip into it that much for other kinds of health care costs. But they are not the people who are most in need of help in affording long-term care or long-term care insurance.

I wouldn't rule out a tax-based approach to helping people afford long-term care insurance, although we would also need to deal with the fact that most employers don't offer long-term care insurance and policies are basically available in the unregulated individual market and there is a lot of cherry-picking and variation based on people's health status.

But if we wanted to do a tax-based approach, it would be much better to look at a refundable tax credit tied to long-term care than to try to do it through these kinds of accounts.

The CHAIRMAN. Does anyone else wish to comment on that? John, any other questions?

Senator BREAUX. Just a couple. I want to make clear that I am a big believer in insurance, particularly in the health care area. I would like to have an individual mandate that everybody has to purchase health insurance and have the government help pay for the premium for those who can't afford it. You bring in a lot of healthier people into the insurance pool if you mandate it across the board. We could establish State purchasing pools so that nobody has to go into the individual market to buy their insurance.

Everybody in America would have health insurance, not because you fit into some box like we currently have, that you get health care if you are old under Medicare, if you are poor under Medicaid, if you are a veteran under the VA benefit, and still have 43 million Americans with no insurance at all. So I am a big believer in everybody having health insurance.

I am also a big believer in copays. I mean, I don't care if it is a dollar. They ought to have some connection with the cost of health care, whether it is buying a prescription at a drug store.

There should be some connection with the purchase of health care and the fact that it costs something.

My concern with HSAs and the high deductible is that for some people that are low income, \$1,500 is a significant deductible that they are going to have a very difficult time coming up with. The argument that, well, there is a connection to the cost, there is certainly no connection after you meet the deductible because everything after that, if it is \$100,000 or \$200,000 a year, is completely covered by health insurance as an incentive to go ahead and use more.

So anyway, my concern is using the tax code in an unprecedented manner. Tax-free going in, tax-free coming out—we have never done that. To create a health care plan which I think is biased toward healthier and younger people is not, I think, a fair use of the tax code. There may be some ways to get this done. I don't think this is it. I also recognize that it is the law and we are going to watch it very carefully.

I thank the panel for their comments.

The CHAIRMAN. John, thank you, and we do thank the panelists for being with us today. It is something we will watch very closely. I don't dispute what my colleague has said. It is an unprecedented move in the market and it will be a significant move if it goes as many of us believe it will, toward changing the dynamics of health care in our country. If not, John, you can come back and tell me, "I told you so." How is that? [Laughter.]

Kate, gentlemen, thank you very much for being with us today and adding to the record as this very important issue develops.

The committee will stand adjourned.

[Whereupon, at 4:11 p.m., the committee was adjourned.]

A P P E N D I X

Statement on

**“Heath Savings Accounts and the New Medicare Law:
The Face of Health Care's Future?”**

**Submitted for the Record
by America’s Health Insurance Plans**

**to the
U.S. Senate Special Committee on Aging**

May 19, 2004

Washington, D.C.

I. Introduction

America's Health Insurance Plans is the largest health trade association in the country, representing over 1,300 companies that provide health benefits to over 200 million Americans. Our member health insurance plans believe that Health Savings Accounts (HSAs) make a valuable contribution to the increasing trend of consumerism in health care, and we applaud the Committee for highlighting this important product.

Consumerism is about giving individuals the incentives and the tools they need to become better consumers of health care. With increased control over funds allocated for their health benefits, consumers will be more engaged in how they spend their money, especially once they become more educated about the actual cost of health services.

This statement provides information on how health insurance plans are advancing HSAs.

II. Health Insurance Plans are Advancing Health Savings Accounts (HSAs)

The 2003 Medicare Modernization Act authorized the development of Health Savings Accounts (HSAs) giving individuals the opportunity to use tax-free funds for current medical expenses and to put aside money for future health care costs. HSAs are established in combination with coverage under a high deductible health plan that meets specified requirements for minimum annual deductibles and out-of-pocket expense limits.¹

In the short time since the passage of this legislation, consumers, employers, and health plans and insurers have expressed considerable interest in HSA products. Currently, 48 health insurance plans are offering high deductible health plans to accompany HSAs, and more companies are actively planning to enter the market.

¹ In 2004 the annual deductible on a qualified HDHP must be at least \$1,000 for self-only coverage and \$2,000 for family coverage. The out-of-pocket limits are \$5,000 for self-only coverage and \$10,000 for family coverage.

Health Savings Accounts are in their infancy. In order for HSAs to be successful, they must meet the needs of individual participants and of the employers who offer HSAs to their individuals. We support an approach that is as flexible as possible to encourage innovation of these new products. Unduly restrictive guidance risks stifling the HSA market.

AHIP has been working with operations and policy staff from member companies to give the Treasury Department information on ways to encourage the development of HSA products through guidance and rulemaking. AHIP has stressed the importance of giving health insurance plans the flexibility to accommodate changing practices and changing market demands; and of accommodating state regulatory requirements.

An important issue concerns the relationship between HSAs and Health Reimbursement Arrangements (HRAs). In deciding whether to offer HSAs, employers will consider how these accounts may be used with HRAs. This issue is particularly important for individuals with existing HRAs. HSAs will be a more attractive health benefits option if employers have flexibility to use these accounts in ways that will best meet their needs and those of their employees.

State Regulatory Requirements

Unfortunately, many states have over the years created a regulatory environment that slows health insurance plans' efforts. It is an environment that fails to serve consumers and employers by simply layering regulatory requirement over regulatory requirement. The result:

- Lack of uniformity of laws, regulations and interpretations from state to state.
- Dual—and frequently inconsistent—regulation by state and federal regulators.
- Absence of regulatory coordination from state to state.

Health insurance plans have to take this complex regulatory environment into account when developing HSA products. Two aspects of the regulatory environment merit special attention: (1) benefit mandates; and (2) speed-to-market.

Benefit mandates

Under the statutory language authorizing HSAs, the high deductible health plans that accompany HSAs cannot provide first-dollar coverage, *except* for preventive care. Recent guidance from the Treasury Department defines preventive care as including:

- Periodic health evaluations, including tests and diagnostic procedures ordered in connection with routine examinations, such as annual physicals.
- Routine prenatal and well-child care.
- Child and adult immunizations.
- Tobacco cessation programs.
- Obesity weight-loss programs.
- Screening services.

However, some states have first-dollar coverage mandates for benefits that may not fit the definition of preventive services. For example, New Jersey requires that hospital service corporations, health service corporations and group health insurers cover screening by blood lead measurement for children and *any necessary medical follow-up and treatment* for lead-poisoned children, without application of a deductible. Pennsylvania requires that all health policies cover medical foods for the treatment of phenylketonuria, branched-chain ketonuria, galactosemia, and homocystinuria without application of a deductible. And in North Dakota, group health plans must cover the first five hours of mental health services without application of a deductible.

Speed-to-market

Every state requires that health insurance plans make form or rate filings before selling a new product in the individual or small group markets. The faster states approve those filings, the faster the speed-to-market of new products for consumers and employers.

Some health insurance plans were immediately ready on January 1, 2004, to sell high deductible health plans to accompany HSAs because those companies already had received state approval to sell high deductible health plan policies. Other health insurance plans, however, had to file new policy forms in various states. AHIP has conducted a survey to ascertain how quickly states are approving new forms.

As of May 13, 2004, health insurance plans responding to the survey reported filing 136 policy forms for individual and group high deductible health plans in 31 states. In 15 of those 31 states, two or more health insurance plans filed forms.

- 83 forms have been approved, generally within 40 days or less.
- However, 53 forms remain pending, some for more than 100 days.

In the 15 states where two or more health insurance plans filed forms: two states approved all forms in 20 days or less (SC, VA); six states approved all forms in 40 days or less (AL, AZ, IL, NE, OH, OK); and the remaining seven states approved some forms, but left other forms pending.

Illinois and Indiana offer a good example of the lack of uniformity in the state approval process for high deductible health plans. As of May 6, four companies have filed policy forms to sell high deductible health plans to small groups in Illinois: one was approved in six days, the others were all approved in 36 days or less. The same four companies filed policy forms for high deductible health plans in Indiana: one was approved in 75 days, and the other three are still pending, the longest for 80 days.

**Status of Company Filings for High Deductible Health Plans
in Illinois and Indiana as of May 6, 2004**

Company	Illinois	Indiana
A	Approved in 6 days	Approved in 75 days
B	Approved in 36 days	Pending for 32 days
C	Approved in 14 days	Pending for 80 days
D	Approved in 30 days	Pending for 70 days

As this experience shows, under the insurance regulatory system as it exists today, it is virtually impossible to craft a compliance system that works across state lines. It is extremely difficult for health insurance plans to standardize and streamline their operational systems if those systems need to be re-calibrated for each state in which they do business.

III. Conclusion

America's Health Insurance Plans and its member companies are committed to developing consumer choice products, such as Health Savings Accounts, that engage individuals in the cost and quality of their health care. However, it is important that policymakers take into consideration the compliance obligations imposed on health plans and insurers by federal and state laws.

- To advance the development of consumerism and HSAs, we call upon state and federal policymakers to give health insurance plans the maximum flexibility possible to design innovative high deductible health plans to accompany HSAs.

- AHIP recommends the Department of the Treasury allow individuals who qualify for an HSA to also participate in a Flexible Spending Arrangement (FSA) or a Health Reimbursement Arrangement (HRA).
- AHIP recommends ending the “use it or lose it rule” for FSAs, and permitting rollovers of up to \$500 annually in these accounts. Even if individuals have an HSA, employers may want to provide them with the option to use an FSA for other qualified expenses. Allowing the roll-over of up to \$500 in unused FSA funds each year – including the transfer of that money into an individual’s HSA – will further advance consumerism.

We look forward to working with the Congress on its continued work on Health Savings Accounts.



Aetna

AdvaMed

American Campaign for
Consumer Choice and
Lower Health CostsAmerican College of
CardiologyAmerican Legislative
Exchange CouncilAmerican Medical
AssociationAmerican Osteopathic
AssociationAmerica's Health Insurance
Plans

Assurant Health

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Health UnderwritersNational Association of
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and Manufacturers of
America

U.S. Chamber of Commerce

UnitedHealth Group

Women Impacting Public
Policy

Wyeth Pharmaceuticals

June 2, 2004

Chairman Larry Craig
Senate Special Committee on Aging
G31 Dirksen Senate Office Building
Washington, D.C. 20510

Dear Chairman Craig:

The Coalition for Affordable Health Coverage is committed to using market-based initiatives to reduce the uninsured by making private health insurance more affordable and available. Our Coalition is broad-based, representing many industries including large and small businesses, medical associations, insurance groups, pharmaceutical companies, and consumer groups.

Last week, your Committee held a hearing to examine the effects of Health Savings Accounts on the availability and price of health insurance and whether or not HSAs will change the dynamics of how we shop and pay for health services. Unfortunately, much of the criticism against HSAs was based upon speculation, and the most recent data on how HSAs are actually impacting the marketplace was not a part of your Committee's record. I would like to submit this letter and attachment for the record.

CAHC believes that Health Savings Accounts are a positive alternative for individuals and businesses and we base that belief on the reports of what is actually happening in the marketplace. Two major companies, eHealthInsurance and Assurant Health, have published information from the first quarter of HSA sales. This information demonstrates that HSAs are:

- Giving uninsured people access to affordable health insurance.
- Being purchased by individuals of all income levels, including lower and lower-middle income.
- Being purchased by all age groups, but primarily by those over age 40.

I have attached a fact sheet presenting key data about who is purchasing HSAs, their socioeconomic background, and whether they were previously uninsured. We would be happy to answer any questions you may have or provide the Committee with more information.

Sincerely,

Laura Clay Trueman
Executive Director



Myth vs. Fact about HSAs

Myth: HSAs will not help the uninsured.

Fact: HSAs have reduced the number of uninsured Americans.

- 40% of HSA applicants did not indicate any prior coverage. (Assurant)
- 32.8% of HSA applicants had not had coverage for at least six months prior to enrollment. (eHealthInsurance)
- Approximately half of all HSA applicants with incomes under \$35,000 had no coverage for at least six months before purchasing an HSA. (eHealthInsurance)

Myth: Only the wealthy will purchase HSAs.

Fact: HSA purchasers come from many income and vocational backgrounds.

- 46% of HSA purchasers have family incomes of less than \$50,000. (eHealthInsurance)
- 36% of all HSA purchasers have only high school or technical school training. (Assurant)
- 38% of HSA purchasers live in homes with a market value of less than \$125,000. (Assurant)
- 27% of HSA purchasers have a net worth of less than \$25,000. (Assurant)

Myth: Only young individuals will purchase HSAs.

Fact: HSA purchasers are older than those purchasing traditional insurance.

- Over 70% of HSA purchasers are over age 40. (Assurant)
- HSAs were purchased by a broad cross section of occupations. Less than 50% of purchasers were from professional and managerial occupations. (Assurant)
- 78% of HSA purchasers are families with children. (Assurant)
- 45% of HSA purchasers are from households of four or more people. (Assurant)
- Single parents with children represent 8% of HSA purchasers/applicants. (Assurant)

Myth: Insurers will only "cherry pick" the healthiest applicants.

Fact: Virtually all HSA applicants have been offered insurance coverage.

- Assurant Health was able to offer coverage to 93.9% of the 17,435 HSA applications received in the first quarter of 2004. (Assurant)

Myth: Insurers will not be able to provide quality, low-cost health insurance to those who purchase HSA-eligible policies.

Fact: Insurers provide comprehensive coverage at a modest cost.

- More than 70% of policies cost under \$100 per person, per month, and almost 95% of policies cost less than \$200 per month. (eHealthInsurance)
- More than 95% of policies require beneficiaries to pay no more than 20% of the cost of office visits, surgery, and diagnostic tests once enrollees meet their deductible. (eHealthInsurance)

Myth: Purchasers of HSAs will defer needed preventive care or avoid taking needed medications.

Fact: Data from the precursors to HSAs (MSAs) indicate enrollees are more likely to use preventive care and generic prescription drugs.

- Preventive care office visits were 31% higher for purchasers of high deductible, tax-qualified medical savings accounts purchased prior to 2004. (Assurant)
- Generic drug usage was consistently higher for purchasers of high deductible tax-qualified medical savings accounts purchased prior to 2004. (Assurant)

Myth: No one will purchase HSAs.

Fact: HSAs have gained wide popularity in the short time since their introduction.

- Assurant Health has applications representing 43,836 members for Individual HSAs in the first four months of 2004. This represents a 60% increase compared to the MSA applications received in the first four months of 2003. (Assurant)

Moving Beyond Speculation: Until recently, predictions about how the newly created Health Savings Accounts would affect consumers, the availability and price of health insurance, and the uninsured have rested on speculation by politicians, economists, and policy analysts.

Now, real data is emerging that provides insight on the potential for HSAs. Contrary to those predicting that HSAs are "only for the healthy, wealthy and young," the facts tell a dramatically different story.

About The Data: The statistics come from two companies selling HSAs and other health insurance products to small businesses and individuals. eHealthInsurance is an online source of health insurance for individuals and small businesses, offering insurance products from a number of carriers nationwide. They provide a broad-based look at what is happening in the market. Assurant Health (formerly Fortis) is one of the largest carriers operating in the individual market. Both began offering HSAs to consumers on January 1, 2004.

